New Patient Form

D/M/Y

Name_____ **Date of Birth**_____

Address_____

Appt Number_____ **City** _____ **Postal Code** _____

Phone-HM (___) _____ **Cell (___)** _____ **Bus (___)** _____

E-mail _____

Physician _____ **Phone (___)** _____

Emergency Contact _____**Phone (___)** _____

How did you hear about our office? _____

Insurance information-Provider_____ **Plan #** _____ **I.D. #** _____

Secondary Insurance - Provider_____ **Plan #** _____ **I.D. #** _____

D/M/Y

Secondary Insr Holder Name: _____**D.O.B.** _____

Health History

1.Have you been under the care of a Medical Doctor during the past two years? **Y / N**
If yes, please explain _____
Physician name: _____Number:_____
2.Have you been hospitalized in the past two years? **Y / N**
If yes, please explain _____
3.When was your last complete physical examination? _____
4.Have you recently, taken any prescription or over the counter medications? **Y / N**
If yes, please list: _____
_____
_____
_____
5.Have you ever reacted adversely to any of the following? (If yes, please circle.)
ANTIBIOTICS – Penicillin, Tetracycline, Sulfonamide, Metronidazole, Erythromycin, Clindamycin, other antibiotics _____
ASPIRIN, IBUPROFEN, other anti-inflammatory medications _____
CODEINE, DEMEROL, PERCODAN, other pain relievers' _____
BARBITURATES (sleeping pills) _____
VALIUM, LOCAL ANAESTHETIC (dental freezing), NITROUS OXIDE. _____
Any other medications? _____
6.Have you ever been advised against taking any specific type of medication? **Y / N**
If yes, please explain _____
7.Do you have any of the following? Asthma, Hay Fever, Food Allergies, Metal or Latex Allergies, Skin Rashes, Hives, or any other allergic condition? (If yes, please circle.)
Do any of these allergic conditions result in headache, nausea, swelling, shortness of breath, or chest constriction? **Y / N**
8.Does any immediate family member have diabetes? **Y / N**
9.Do you bleed excessively from a cut or injury, or bruise easily? **Y / N**
10.Do your ankles, feet or hands swell? **Y / N**
11.Has your weight, appetite, or energy level changed dramatically recently? **Y / N**
12.Do you experience shortness of breath or chest pain when climbing stairs? **Y / N**
13.Have you ever tested HIV positive? **Y / N**
14.Do you have Frequent severe headaches, earaches, ear/throat infections? **Y / N**
15.Have you ever had any injury or surgery to your face or jaws? **Y / N**
16.Are you alcohol and/or drug dependant? **Y / N**
17.Do you smoke or use any other forms of tobacco? **Y / N**
If so, in what amount: _____ cigarettes/day, for _____ years. Nicotine patch?_____

Please Indicate which of the following you presently have or have ever had:

Please indicate by circling

A.I.D.S	Head/neck injuries	Malignant Hyperthermia
Anemia	Heart disease or attack	Mental/Nervous disorder
Angina pectoris	Heart murmur	Mitral valve prolapse
Arthritis/rheumatism	Heart pacemaker	Organ transpalant
Artificial heart valve	Heart rhythm disorder	Medical implant
Artificial joints (hik/knee)	Heart surgery	Radiation treatment
Blood disorders	Hepatitis A	Rheumatic/Scarlet fever
Bronchitis	Hepatitis B	Sickle cell disease
Cancer	Hepatitis ( )	Sinus trouble
Circulation problems	Herpes	Stomach/intestinal issues
Congenital heart lesions	High/Low blood pressure	Stroke
Cortisone/steroid	Hodgkins disease	Thyroid disease
Diabetes (type 1 or 2)	Hyper/Hypo Glycemia	Tuberculosis
Emphysema	Hypertension	Ulcers
Epilepsy or seizures	Jaundice	Venereal disease
Fainting or dizzy spells	Kidney disease	Other:
Glandular disorders	Liver disease	Other:
Glaucoma	Lung disease	Other:

18.Do you currently have, or have you had in the past, any disease, condition or problem not listed above? _____

19.Is there anything else about your health we should be aware of? _____

_____

_____

Child Patient

Has the child recently had any of the following (please indicate year):

Measles _____, Mumps _____, Chicken pox _____, Strep throat _____, Tonsillitis _____.

Female Patients

Are you pregnant or suspect you may be**?** **Y / N** If yes, how many weeks? _____

Are you taking any birth control? **Y / N** What type? _____

Dental History

Date of your last Dental visit: _____ **D/M/Y** Last Cleaning _____ **D/M/Y**

Last full mouth x-rays _____ **D/M/Y** Last Panorex x-ray _____ **D/M/Y**

1. What do you feel is the most important feature about a Dental Office? _____

_____

2. Are you having any pain or are you aware of any dental problem? _____

_____

3. Have you ever had any of the following? (Please indicate year) **D/M/Y**
   - Periodontal treatment? (treatment of the gums) _____
   - Orthodontic treatment? (to straighten or realign teeth) _____
   - Oral surgery? (surgery in or about the mouth or jaw) _____
   - A bite plate adjusted or teeth ground? _____
   - Dental implants, or implant surgery in one or both of your jaw joints? _____

   If yes to the last question, who performed the surgery? _____

   When was the surgery performed?_____

4. Are there any growths or sore spots in your mouth? **Y / N**
5. Do your gums bleed when brushing or eating? **Y / N**
6. Do you suffer from pain or swelling of your gums? **Y** / N
7. Have you noticed any loose teeth, or have any shifted? **Y / N**
8. Does food catch between your teeth? **Y / N**
9. Are any of your teeth sensitive to heat, cold, sweets, or pressure? **Y / N**
10. Do you use dental floss, proxabrush or stimudents? How often? _____
11. How often do you brush your teeth? _____
12. Have you experienced any of the following jaw problems:
    - Popping/clicking in your jaw joints? **Y / N**
    - Pain in your jaw joints, around your ear, or side of your face? **Y / N**
    - Difficulty in opening or closing your mouth? **Y / N**
    - Pain when teeth are clenched? **Y / N**
    - Pain or difficulty while chewing? **Y / N**

13. Do you have any of the following habits?
    - Clenching or grinding your teeth while awake or asleep? **Y / N**
    - Biting your cheeks or lips? **Y / N**
    - Mouth breathing while asleep or awake? **Y / N**
    - Placing foreign object in your mouth (pencils, nails, fingernails etc) **Y / N**
14. Do you have any emotional concerns about having dental treatment? **Y / N**
15. Are you happy with the appearance of your teeth? **Y / N**

    If not, what would you like to change? _____
16. Do you have any questions or concerns? _____

_____

_____

General Release

I, the undersigned, certify that I have provided an accurate and complete personal and medical dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to the questions regarding my medical – dental history. I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that the information provided from or to my medical doctor or another health care provider may be necessary, and I consent to the release of this information. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

_____ _____

Print name of Patient/Parent/Guardian Signature of Patient/Parent/Guardian

_____ _____

Witness Date

NOTE: IT IS IMPORTANT THAT ANY CHANGE IN YOUR HEALTH STATUS BE REPORTED TO OUR OFFICE.

Reviewed by treating Dentist _____ Date: _____