New Dental Patient Form

In order to provide you the best possible Dental Care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

New Patient Data

First Name _____ Last Name _____ Date _____ Email* _____

* Your email will NOT be shared with any 3d parties, and is used for occasional practice announcements and promotions.

Mailing address

Address _____ City _____ State _____ Zip _____

Telephone (Work) _____ (home) _____ Referred By _____

Age _____ Birth Date _____ Social Security # _____ Number of Children _____

Occupation _____ Employer _____

Marital Status _____ Spouse's Name _____ Spouse's Occupation _____

Spouse's Employer _____ Spouse's Health Status _____

Emergency Contact _____ Phone _____

Current Complaints

Describe the main purpose of your visit:

Have you considered a smile makeover? ○ No ○ Yes

Have you considered Tooth Whitening? ○ No ○ Yes

Have you ever had cosmetic dentistry? ○ No ○ Yes

If yes, describe? _____

Are you currently experiencing dental pain? ○ No ○ Yes

If yes, describe: _____

Insurance Information

Name of party responsible for payment _____ Phone _____

Do you have dental insurance? ○ No ○ Yes

Name of company _____

Signatures

Name of the insured _____

I understand and agree that dental insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature _____ Date _____

Spouse's or guardian's signature _____ Date _____

Medical History

Have you been treated for any conditions in the last year? ○ No ○ Yes

If yes, please describe

Date of last physical exam

Is there a chance that you are pregnant? ○ No ○ Yes

Have you had X-rays taken? ○ No ○ Yes

If Yes, where?

What medications are you taking and for what conditions (Please list dosage and amounts,

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency).

Family History

Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Misc Pain and Symptoms

Do you experience dental pain every day?	○ No ○ Yes
Do your symptoms interfere with daily life?	○ No ○ Yes
Do you grind your teeth at night?	○ No ○ Yes
Does hot or cold cause pain in your teeth?	○ No ○ Yes

Habits	None	Light	Moderate	Heavy
Alcohol	○	○	○	○
Coffee	○	○	○	○
Tobacco	○	○	○	○
Drugs	○	○	○	○
Exercise	○	○	○	○
Sleep	○	○	○	○
Appetite	○	○	○	○
Soft Drinks	○	○	○	○
Water	○	○	○	○
Salty Foods	○	○	○	○
Sugary Foods	○	○	○	○
Artificial Sweeteners	○	○	○	○