New Patient Information

Name:
Last First MI Title

Preferred Name: **Date of Birth:**

SSN: **(Please Circle)** Male Female

Address:
Street City State ZIP

Contact:
Home Phone Work Phone Cell Phone

Email

Employer: **Occupation:**

Do you prefer to be contacted for appointment confirmation by email or phone?

How did you hear about our office?

Medical History

Do you have a physician?

Physician's Name:

Physician's Phone:

Date of Last Visit/Exam:

How would you rate your health? **(Please Circle)** Good Fair Poor

Please Circle:

Yes / No **Do you take any medications?**

If yes, please list:

Yes / No **Do you take Fosomax, Actonel, or Boniva?**

If yes, please list:

Yes / No **Have you ever had surgery or been hospitilized?**

If yes, please describe:

Yes / No **Do you use any form of tobacco?**

If yes, please describe: ____________________

Yes / No **Do you have any allergies? (medications, food, materials, etc.)**

If yes, please list: ____________________

Do you have or have you ever had any of the following conditions?

Yes / No Abnormal Bleeding
Yes / No Alcohol Abuse
Yes / No Anemia
Yes / No Angina Pectoris
Yes / No Arthritis
Yes / No Artificial Heart Valve
Yes / No Asthma
Yes / No Blood Transfusion
Yes / No Cancer
Yes / No Chemotherapy
Yes / No Colitis
Yes / No Congenital Heart Defect
Yes / No Diabetes
Yes / No Drug Abuse
Yes / No Emphysema
Yes / No Epilepsy
Yes / No Fainting Spells
Yes / No Fever Blisters
Yes / No Glaucoma
Yes / No HIV or AIDS
Yes / No Heart Attack
Yes / No Heart Murmur
Yes / No Heart Surgery
Yes / No Hemophilia
Yes / No Hepatitis A
Yes / No Hepatitis B
Yes / No Hepatitis C
Yes / No High Blood Pressure
Yes / No Joint Replacement
Yes / No Kidney Disease
Yes / No Liver Disease
Yes / No Low Blood Pressure
Yes / No Mitral Valve Prolapse
Yes / No Pacemaker
Yes / No Psychiatric Problems
Yes / No Radiation Therapy
Yes / No Rheumatic Fever
Yes / No Seizures
Yes / No Sexually Transmitted Disease
Yes / No Shingles
Yes / No Sickle Cell Disease
Yes / No Sinus Problems
Yes / No Stroke
Yes / No Thyroid Problems
Yes / No Tuberculosis
Yes / No Ulcers

If Female, please answer the following:

Yes / No Are you taking birth control pills?
Yes / No Are you pregnant? If so, how many weeks? ________
Yes / No Are you nursing?

Dental History

How may we help you today? ____________________

How would you rate your dental health? **(Please Circle)** Good Fair Poor

Yes / No Do you require antibiotics before dental treatment?

Yes / No Are you in pain?

Yes / No Are your teeth sensitive to hot, cold, or anything else?

Yes / No Have you ever had any gum treatment?

Yes / No Do your gums bleed?

Yes / No Do you have any pain or discomfort in your jaw joint (TMJ)?

Yes / No Do you like your smile?

Yes / No Is there anything you would like to change about your smile?

Yes / No Are you happy with the color of your teeth?

Yes / No Have you ever had a serious problem with any previous dental work?

Yes / No Have you ever had an unfavorable dental experience?

____________ When was your last dental visit?

____________ When was your last cleaning?

____________ How many times a day do you brush?

____________ How many times a week do you floss?

How can we accommodate you better during your dental visit?

____

____

Please circle any services below that you would like to discuss during your visit:

Bridges	Composite Bonding	Crowns	Night Guards
Sealants	Partials/Dentures	Veneers	Whitening