New Patient Information

Whom may we thank for referring you? _____ Date: _____

First Name: _____ Last Name: _____ Preferred Name: _____

Mailing Address: _____ City _____ State ___ Zip _____

Home Phone: (___)_____ Cell: (___)_____ Email: _____

Birth Date: __/__/__ Age: ___ Male: ☐ Female: ☐ S.S.# _____

Marital status: Married ☐ Single ☐ Minor ☐ Are you a full-time student? Yes ☐ No ☐

Employed by: _____ Work Phone: _____

PERSON RESPONSIBLE FOR ACCOUNT

☐ Same as above name: _____ Birth Date: __/__/__ Relation: _____

Mailing Address _____ City _____ State ___ Zip _____

Home Phone: (___) _____ Cell: (___) _____ S.S.# _____

Employer: _____ Work Phone: (___) _____

As patient or legal guardian of a minor patient, I agree to pay for all services rendered in accordance with the terms and conditions set forth in the financial policy of this office. I hereby authorize all money to which I am entitled for expense relative to the services performed from time to time, but not to exceed my indebtedness to said doctor. I understand that after 90 days, all accounts are subject to a finance charge of 1 1/2% of the unpaid balance (or a minimum charge of 50 cents), which is an annual percentage rate of 18%. I understand that a $5.00 late charge may accrue f I miss my monthly payment. **I understand that I am financially responsible for all charges whether or not paid by insurance.**

Patient /Responsible Party's Signature: _____

EMERGENCY CONTACT / SPOUSE INFORMATION

Name: _____ Relation: _____

Home Phone: (___) _____ Cell Phone: (___) _____

DENTAL INSURANCE INFORMATION

Primary Insurance

Insurance Co. Name: _____ Phone: (___) _____ Group/Policy#: _____

Insured's Name: _____ Insured's Birth Date: __/__/__ Relation: _____

Insured's ID: _____ Insured's Employer: _____

Secondary Insurance

Insurance Co. Name: _____ Phone: (___) _____ Group/Policy#: _____

Insured's Name: _____ Insured's Birth Date: __/__/__ Relation: _____

Insured's ID: _____ Insured's Employer: _____

Medical Insurance (Some procedures may be billed to medical)

Insurance Co. Name: _____ Phone: (___) _____ Group/Policy#: _____

Insured's Name: _____ Insured's Birth Date: __/__/__ Relation: _____

Insured's ID: _____ Insured's Employer: _____

MEDICAL HISTORY INFORMATION

Name of Physician: _____ Phone: (___)_____

Do you have or have ever had any of the following? **PLEASE CHECK THOSE THAT APPLY:**

- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Artificial Joints*
- ☐ Artificial Heart Valves*
- ☐ Asthma
- ☐ Breathing Problems
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Diabetes (NIDDM/IDDM)
- ☐ Epilepsy or Seizures
- ☐ Excessive Thirst
- ☐ Fainting or Dizziness
- ☐ Fever Blisters/Cold Sores
- ☐ Frequent Cough
- ☐ Excessive Bleeding
- ☐ Heart Disorder (Congenital)*
- ☐ Heart Infection*
- ☐ Heart Murmur*
- ☐ Heart Pace Maker*
- ☐ Heart Surgery
- ☐ Hepatitis A, B, C
- ☐ High Blood Pressure
- ☐ HIV*/AIDS
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse*
- ☐ Osteoporosis
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Surgical Shunt*
- ☐ Thyroid Problems
- ☐ Tobacco Use
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

YES NO

☐ ☐ Have you been required to take antibiotic premedication for certain dental procedures?
If yes, explain: _____

☐ ☐ Have you ever taken Bisphosphonates (ie: Fosamax, Actonel, Zometa)?
If yes, explain: _____

☐ ☐ Do you have any health problems that were not listed above or need further clarifications?
If yes, explain: _____

☐ ☐ Are you now under the care of a physician?
If yes, explain: _____

☐ ☐ Have you been admitted to a hospital or needed emergency care during the past two years?
If yes, explain: _____

☐ ☐ Are you taking any medications?
If yes, list: _____
Are you taking Aspirin ☐ Blood Thinner ☐

☐ ☐ Are you allergic to any medications or substances?
If yes, please check box below:
Aspirin ☐ Penicillin ☐ Codeine ☐ Novocaine/ Lidocaine ☐ Metal ☐ Latex ☐ Other_____

☐ ☐ Are you being treated for chronic pain?
Doctor:_____ Phone:_____

☐ ☐ WOMEN: are you Pregnant? Due date:_____

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I will inform the dentist and the staff the next appointment without fail.

X _____ Date _____
Signature of patient, parent or guardian

MEDICAL UPDATES

I have read my MEDICAL HISTORY dated _____ and confirm that it states past and present conditions.

Date:	Exceptions:	Patient's Signature:
_____	_____	None X _____
_____	_____	None X _____
_____	_____	None X _____