

NEW PATIENT INFORMATION

Patient's Name _____ How did you hear of our practice? _____
 (please print)

DENTAL HEALTH

Why did you seek dental treatment? _____
 Do you have any dental problems which require immediate attention? Yes _____ No _____
 if yes, please explain _____
 When was your last visit to a dentist for routine care? _____ For emergency care? _____
 Are you dissatisfied with the appearance of your teeth? Yes _____ No _____
 Do your gums bleed when you brush? Yes _____ No _____
 Do you frequently grind or clench your teeth? Yes _____ No _____
 Are you fearful about visiting the dentist? Yes _____ No _____
 What did you like or not like about your previous dentist? _____

MEDICAL HEALTH

How is your general health? Excellent Good Fair Poor
 Who is your physician? Dr. _____ Address _____ Tel. _____
 Do you have now or have you ever had any major medical problems? Yes _____ No _____
 Have you ever been hospitalized? Yes _____ No _____
 Are you now, or have you recently been taking any drug or medication? Yes _____ No _____
 If so what _____
 Are you allergic or sensitive to any drugs or medicine (e.g. penicillin, aspirin)? Yes _____ No _____
 If so what _____
 Do you have any difficulty with bleeding or healing from a cut, wound, or extraction? Yes _____ No _____
 Were you ever premedicated for dental treatment? Yes _____ No _____
 Do you have or have you ever had any of the following problems?

	Yes	No		Yes	No		Yes	No
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Angina or Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disease	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>
Anemia or Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or Growths	<input type="checkbox"/>	<input type="checkbox"/>	A.I.D.S.	<input type="checkbox"/>	<input type="checkbox"/>
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Seizure Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Stomach I intestinal (ulcers)	<input type="checkbox"/>	<input type="checkbox"/>	Women: Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>

None of the above If yes to any of the above, please explain _____

I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND I GIVE PERMISSION FOR ANY NECESSARY DENTAL TREATMENT

Signature _____ Date _____
 (patient/guardian)

Doctor's Notes _____

MEDICAL HISTORY UPDATED BY	DATE	MEDICAL HISTORY UPDATED BY	DATE

NEW PATIENT INFORMATION

PATIENT'S NAME (PLEASE PRINT)		SEX		DATE OF BIRTH	AGE	SOCIAL SECURITY NO.	MARITAL STATUS				
		M	F				S	M	W	D	SEP
STREET ADDRESS <input type="checkbox"/> PERMANENT <input type="checkbox"/> TEMPORARY		CITY, STATE, ZIP				HOME PHONE NO.					
PATIENT'S EMPLOYER (IF STUDENT, NAME OF SCHOOL)		OCCUPATION (IF STUDENT <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME)			HOW LONG EMPLOYED / YEAR AT SCHOOL		BUSINESS PHONE NO.				
EMPLOYER'S STREET ADDRESS		CITY, STATE, ZIP				EXTENSION					
SPOUSE'S NAME		SPOUSE'S SOCIAL SECURITY NO.			NUMBER OF CHILDREN AND AGE						
SPOUSE'S EMPLOYER		OCCUPATION (IF STUDENT <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME)			HOW LONG EMPLOYED / YEAR AT SCHOOL		BUSINESS PHONE NO.				
EMPLOYER'S STREET ADDRESS		CITY, STATE, ZIP				EXTENSION					
CLOSE RELATIVE IN CASE OF EMERGENCY		RELATIONSHIP				HOME PHONE NO.					
RELATIVE'S STREET ADDRESS		CITY, STATE, ZIP									

IF THE PATIENT IS A MINOR OR STUDENT

MOTHER'S NAME		STREET ADDRESS, CITY, STATE, ZIP			HOME PHONE NO.	
MOTHER'S EMPLOYER		OCCUPATION		HOW LONG EMPLOYED?		BUSINESS PHONE NO.
EMPLOYER'S STREET ADDRESS		CITY, STATE, ZIP			EXTENSION	
FATHER'S NAME		STREET ADDRESS, CITY, STATE, ZIP			HOME PHONE NO.	
FATHER'S EMPLOYER		OCCUPATION		HOW LONG EMPLOYED?		BUSINESS PHONE NO.
EMPLOYER'S STREET ADDRESS		CITY, STATE, ZIP			EXTENSION	

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY TREATMENT PERFORMED, WHETHER OR NOT I HAVE DENTAL INSURANCE.

PLEASE SIGN

SIGNATURE (PATIENT / GUARDIAN)

DATE

INSURANCE INFORMATION: IF YOU WISH US TO PROCESS INSURANCE CLAIMS, THIS PORTION MUST BE COMPLETED.

1st OR PRIMARY INSURANCE CARRIER	2nd OR SECONDARY INSURANCE CARRIER	MEDICAL INSURANCE CARRIER
EMPLOYER'S NAME	EMPLOYER'S NAME	EMPLOYER'S NAME
EMPLOYER'S ADDRESS	EMPLOYER'S ADDRESS	EMPLOYER'S ADDRESS
EMPLOYEE/SUBSCRIBER NAME	EMPLOYEE/SUBSCRIBER NAME	EMPLOYEE/SUBSCRIBER NAME
SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S DATE OF BIRTH
EMPLOYEE/SUBSCRIBER SOCIAL SECURITY NO.	EMPLOYEE/SUBSCRIBER SOCIAL SECURITY NO.	EMPLOYEE/SUBSCRIBER SOCIAL SECURITY NO.
PATIENT'S RELATIONS TO EMPLOYEE / SUBSCRIBER <small>SELF SPOUSE CHILD OTHER</small>	PATIENT'S RELATIONS TO EMPLOYEE / SUBSCRIBER <small>SELF SPOUSE CHILD OTHER</small>	PATIENT'S RELATIONS TO EMPLOYEE / SUBSCRIBER <small>SELF SPOUSE CHILD OTHER</small>
INS. COMPANY NAME	INS. COMPANY NAME	INS. COMPANY NAME
ADDRESS	ADDRESS	ADDRESS
GROUP PLAN _____ GROUP _____	GROUP PLAN _____ GROUP _____	GROUP PLAN _____ GROUP _____
NAME _____ PLAN# _____	NAME _____ PLAN# _____	NAME _____ PLAN# _____
CERTIFICATE/ _____ UNION/ _____	CERTIFICATE/ _____ UNION/ _____	CERTIFICATE/ _____ UNION/ _____
POLICY# _____ LOCAL# _____	POLICY# _____ LOCAL# _____	POLICY# _____ LOCAL# _____
DEDUCTIBLES <input type="checkbox"/> YES <input type="checkbox"/> NO \$ _____	DEDUCTIBLES <input type="checkbox"/> YES <input type="checkbox"/> NO \$ _____	DEDUCTIBLES <input type="checkbox"/> YES <input type="checkbox"/> NO \$ _____
MAXIMUM BENEFIT PER YEAR \$ _____	MAXIMUM BENEFIT PER YEAR \$ _____	MAXIMUM BENEFIT PER YEAR \$ _____

I HEREBY AUTHORIZE RELEASE OF INFORMATION RELATING TO THE TREATMENT NECESSARY TO PROCESS INSURANCE CLAIMS.
 I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DDS DENTAL CENTER OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.
 I HEREBY AUTHORIZE ANY CHARGES NOT COVERED BY MY INSURANCE COMPANY TO BE PAID DIRECTLY WITH MY DDS CREDIT CARD.

SIGNED (PATIENT / GUARDIAN)

DATE

SIGNED (INSURED PERSON)

DATE

PATIENTS ARE EXPECTED TO MAKE PAYMENT WHEN SERVICES ARE RENDERED.

THE INVESTMENT NECESSARY TO COMPLETE DENTAL TREATMENT IS AN ESTIMATE BASED ON INFORMATION FROM OUR EXAMINATION SHOULD ADDITIONAL PROBLEMS ARISE, AS TREATMENT PROGRESSES, THIS ESTIMATE MAY BE REVISED THIS ESTIMATE WILL BE HONORED FOR A PERIOD OF THREE (3) MONTHS ONLY