New Patient Information Form

Name _____ Date _____
First Middle Last

Address _____ City _____ State _____ Zip _____

Cell # _____ Home phone _____ Birthdate _____

Email _____ Soc. Security # _____

Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated Sex: M F

Spouse or parent's name _____ Employer _____ Work phone _____

Whom may we thank for referring you? _____

Person to contact in case of an emergency _____ Phone _____

Insurance Information

Name of insured _____ Relationship to patient _____

Birth date _____ Soc. Security # _____ Date employed _____

Name of employer _____ Work phone _____

Insurance Co. _____ Tel. # _____ Grp. # _____ Policy/I.D.# _____

Do you have any additional insurance ☐ Yes ☐ No

Medical History

Name of Former Dentist _____ Date of Last Dental Examination _____

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? _____
Yes No Are you allergic to any medication? _____
Yes No Do you have a history of a major illness? _____
Yes No Have there been any injuries to face, mouth, or teeth? _____
Yes No (Women) Do you suspect you are pregnant? _____
Yes No (Women) Are you taking birth control medication? _____
If patient is a child, what is his/her weight? _____

Have you ever had any of the following? (all boxes must be checked YES or NO)

Yes	No		Yes	No		Yes	No	
☐	☐	Abnormal bleeding/Hemophilia	☐	☐	Diabetes	☐	☐	Nervous Disorders
☐	☐	AIDS or Other Immunosuppressive Disorders	☐	☐	Dizziness	☐	☐	Osteoporosis
☐	☐	Allergies to Anesthetics or Medication	☐	☐	Epilepsy	☐	☐	Prolonged Bleeding
☐	☐	Anemia	☐	☐	Gastrointestinal Disorders	☐	☐	Psychiatric Care
☐	☐	Artificial Joints or Heart Valves	☐	☐	General Allergies	☐	☐	Radiation/Chemotherapy
☐	☐	Arthritis	☐	☐	Headaches	☐	☐	Recent Weight loss
☐	☐	Asthma or Hay fever	☐	☐	Heart Murmur	☐	☐	Rheumatic Fever
☐	☐	Back Problems	☐	☐	Hepatitis/Liver problems	☐	☐	Sinus Problems
☐	☐	Blood Disease	☐	☐	Hepatitis C	☐	☐	Smoker ___/day
☐	☐	Bone Disorders	☐	☐	Hemophilia	☐	☐	Stroke
☐	☐	Chemical Dependency	☐	☐	Herpes	☐	☐	Tuberculosis
☐	☐	Chronic Diarrhea	☐	☐	High Blood Pressure	☐	☐	Tumor or Cancer
☐	☐	Circulation Problems	☐	☐	Implants	☐	☐	Used Phen- Phen
☐	☐	Congenital Heart Defect	☐	☐	Kidney problems	☐	☐	Ulcer
			☐	☐	Latex Allergy	☐	☐	Venereal Disease

ACKNOWLEDGEMENT AND AUTHORITY

I consent to treatment as necessary or desirable to the care of the patient first named above, including but not restricted to whatever drugs, medicine, performance of operations and conduct of laboratory, x-ray, or other studies that may be used by the attending doctor, or assistant, or qualified designate. The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing or processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I also acknowledge full responsibility for the payment of such services and agree to pay for them, in full, AT THE TIME OF SERVICE. In the event of default of payment your account will be turned over to a collection agency. I agree to pay all reasonable court costs, attorney fees and collection fees in addition to the original fee.

Signature: _____ Date: _____