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	☐	☐	Allergies	☐	☐	Liver Disease	☐	☐
Heart Murmur	☐	☐	Nervous Disorder	☐	☐	Thyroid Problems	☐	☐
Heart Disease	☐	☐	Fainting Spells	☐	☐	Sinus Problems	☐	☐
Angina or Chest Pain	☐	☐	Diabetes	☐	☐	Skin Disease	☐	☐
High Blood Pressure	☐	☐	Arthritis	☐	☐	Venereal Disease	☐	☐
Stroke	☐	☐	Cancer	☐	☐	Herpes	☐	☐
Anemia or Blood Disease	☐	☐	Tumors or Growths	☐	☐	A.I.D.S.	☐	☐
Lung Disease	☐	☐	Kidney Disease	☐	☐	Hepatitis	☐	☐
Asthma	☐	☐	Seizure Disorders	☐	☐	Glaucoma	☐	☐
Hay Fever	☐	☐	Stomach I intestional (ulcers)	☐	☐	Women: Are you pregnant?	☐	☐

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 M	SEX F	DATE OF BIRTH	AGE	SOCIAL SECURITY NO.	MARITAL STATUS S	M	W	D	SEP

STREET ADDRESS ☐ PERMANENT ☐ TEMPORARY	CITY, STATE, ZIP		HOME PHONE NO
PATIENT S EMPLOYER (IF STUDENT, NAME OF SCHOOL)	OCCUPATION (IF STUDENT ☐ FULL TIME ☐ 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 ☐ FULL TIME ☐ 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 SELF SPOUSE CHILD OTHER	PATIENT'S RELATIONS TO EMPLOYEE / SUBSCRIBER SELF SPOUSE CHILD OTHER	PATIENT'S RELATIONS TO EMPLOYEE / SUBSCRIBER SELF SPOUSE CHILD OTHER
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 ☐ YES ☐ NO $	DEDUCTIBLES ☐ YES ☐ NO $	DEDUCTIBLES ☐ YES ☐ 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