Your clinic's logo here.

Your Clinic Name & Address Here

DENTAL CLINIC NEW PATIENT FORM

Thank you for selecting our dental office. To help us meet all of your health care needs, please complete this form as accurately as possible. Thank you.

1) PATIENT INFORMATION

This appointment is for ☐ Yourself ☐ Your Child

Patient Full Name _____ Social Security # _____

Birth Date _____ Age _____ ☐ Male ☐ Female

Address _____

City _____ State ____ Zip _____

Full Time Student ☐ Yes ☐ No School Name _____

Employer _____ Occupation _____

Previous Dentist _____ Previous Dentist Phone _____

Current Physician _____ Current Physician Phone _____

Whom may we thank for referring you? _____

2) TELEPHONE & EMAIL

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____

In the event of an emergency, who should we contact? Name _____

Relationship _____ Home Phone _____ Work Phone _____

3) RESPONSIBLE PARTY

Who is responsible for this patient?

Full Name _____ Social Security # _____

Are you ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Birth Date _____ Age _____ ☐ Male ☐ Female

Address _____

City _____ State ____ Zip _____

Employer _____ Occupation _____

Home Phone _____ Work Phone _____

4) INSURANCE INFORMATION

Dental Coverage ☐ Yes ☐ No

Insured's Name _____ Relation _____

Insured's Social Security # _____ Birth Date _____

Insurance Group # _____ Insurance Policy # _____

Insurance Co. Name _____ Insurance Co Phone _____

5) DENTAL HISTORY

Why have you come to the dentist today? _____

Do you require antibiotics before dental treatment?	☐ Yes	☐ No
Are you currently in pain?	☐ Yes	☐ No
Do your gums ever bleed?	☐ Yes	☐ No
Have you ever had difficulties associated with any previous dental work?	☐ Yes	☐ No
Do you or have you ever experienced pain in your jaw joint (TMJ / TMD)?.	☐ Yes	☐ No
Have your tonsils or adenoids been removed?	☐ Yes	☐ No
Do you floss on a regular basis?	☐ Yes	☐ No

6) MEDICAL HISTORY

Do you consider yourself in good medical health?	☐ Yes	☐ No
Are you taking any medications?	☐ Yes	☐ No
If so, please list here _____		
Are you allergic to any medications?	☐ Yes	☐ No
If so, please list here _____		
(Women) Are you currently pregnant?	☐ Yes	☐ No
If so, how many weeks? _____		
(Women) Are you nursing?	☐ Yes	☐ No
(Women) Are you taking birth control?	☐ Yes	☐ No
Are you allergic to aspirin?	☐ Yes	☐ No
Are you allergic to codeine?	☐ Yes	☐ No
Are you allergic to dental anesthetics?	☐ Yes	☐ No
Are you allergic to erythromycin?.	☐ Yes	☐ No
Are you allergic to latex or rubber products?	☐ Yes	☐ No
Are you allergic to metals?	☐ Yes	☐ No
Are you allergic to penicillin?	☐ Yes	☐ No
Are you allergic to tetracycline?	☐ Yes	☐ No

Have you ever had any of the following medical problems?

Abnormal bleeding	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No
Alcohol / Drug abuse	☐ Yes	☐ No	Herpes / Fever Blisters	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	HIV / AIDS	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Liver Problems	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No
Difficulty Breathing	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Fainting Spells	☐ Yes	☐ No	Shingles	☐ Yes	☐ No
Frequent Headaches	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Sinus Problems	☐ Yes	☐ No
Hay Fever	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Heart Surgery	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No

4) ACKNOWLEDGEMENT & AUTHORIZATION

I certify that I have read and understand the above. I acknowledge that my questions have been answered truthfully and to the best of my knowledge. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

SIGNATURE _____ DATE _____