

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