NEW PATIENT INFORMATION FORM

LAST NAME: _____ FIRST NAME_____ MIDDLE: _____

NICKNAME: _____ SS#: ____-____-_____

HOME ADDRESS: _____ CITY _____ ZIP_____

HOME PHONE: _____ WORK PHONE: _____ CELL: _____

DOB: ____/____/_____ MARITAL STATUS: _____ SEX: _____

EMPLOYER NAME AND ADDRESS: _____

REFERRING DR: _____ REFERRING PT: _____

PRIMARY INSURANCE COVERAGE

SUBSCRIBER NAME AND ADDRESS: _____

RELATION TO PATIENT: _____ SS#: ____-____-_____ DOB: ____/____/____

EMPLOYER NAME AND ADDRESS: _____

INSURANCE COMPANY NAME AND ADDRESS: _____

GROUP #: _____ FAMILY YRLY DEDUCT: _____ INDIV YRLY DEDUCT: _____

SECONDARY INSURANCE COVERAGE

SUBSCRIBER NAME AND ADDRESS: _____

RELATION TO PATIENT: _____ SS#: ____-____-_____ DOB: ____/____/____

EMPLOYER NAME AND ADDRESS: _____

INSURANCE COMPANY NAME AND ADDRESS: _____

GROUP #: _____ FAMILY YRLY DEDUCT: _____ INDIV YRLY DEDUCT: _____

RESPONSIBLE PARTY FOR PATIENT:

Name and Address: _____

Signature: _____

Please write any additional insurance information on the back of this form - Thank You!

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ have received a copy of this office's Notice of Privacy Practices.

_____ _____

Signature Date

(You May Refuse to Sign This Acknowledgement)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other _____

PATIENT MEDICAL INFORMATION

PATIENT NAME : _____ DATE : _____

PREFERRED NAME (NICKNAME): _____ DATE OF BIRTH : _____

SEX : M F

IS YOUR GENERAL HEALTH GOOD ? ..... YES ___ NO ___
DO YOU SMOKE OR USE TOBACCO? ..... YES ___ NO ___
ARE YOU USING BIRTH CONTROL PILLS/IMPLANT? YES ___ NO ___
ARE YOU PREGNANT? ..... YES ___ NO ___

Y	N	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Bones
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer- Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Cosmetic Surgery
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Fever Blisters
☐	☐	Frequent Headaches

Y	N	Conditions
☐	☐	Glaucoma
☐	☐	Hay Fever
☐	☐	Heart Attack
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	High Blood Pressure
☐	☐	HIV+ AIDS
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Pneumocystitis
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Shingles
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems

Y	N	Conditions
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Venereal Disease
☐	☐	Yellow Jaundice

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

_____
_____
_____

MEDICATIONS YOU ARE TAKING	REASON

APPROXIMATE TIME SINCE LAST DENTAL EXAM ? _____

PHYSICIAN : _____

Person filling out Medical History _____

REFERRED BY: NAME _____

YELLOW PAGES _____
SIGN OUT FRONT _____

THANK YOU !

Gary W. Stewart, D.D.S.
Jacob D. Young, D.D.S.
Family Dentistry