New Patient Information

Patient's name _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Marital Status: (Circle one) S M D Sep. W Patient is: M ( ) Female ( ) Child ( )

Birth date _____ Home Phone # _____ Cell # _____

Work # _____ E-mail (Home or Work)_____

Employer _____ City-State _____ Occupation _____

Name of Parent / Guardian _____ SSN # _____
(Circle one)

Employer _____ City-State _____ Occupation _____

In case of Emergency, whom shall we notify ?

Name _____ Relationship _____ Phone _____

Who will be responsible for this account: _____?

Dental Insurance Information:

Employee Name _____

Ins. Co. Name_____

Ins. Co. Address _____

Ins. Co. City, ST, Zip _____

Insurance Phone# _____

Group / Policy # _____

Employee SSN # _____

Employee Birth date _____

Secondary Dental Insurance Information:

Employee Name _____

Ins. Co. Name _____

Ins. Co. Address _____

Ins. Co. City, ST, Zip _____

Insurance Phone# _____

Group / Policy # _____

Employee SSN # _____

Employee Birth date _____

Who can we "Thank" for referring you to our Office: _____?

Medical Questionaire

Name: _____ Date of Birth:_____

Do you feel you are in good health ? Yes No

Are you presently under a physicians care ? Yes No

Date of your Last Physical _____

Name of Physician _____ Physician's Telephone # _____

Physicians Address _____ _____

Please list **ANY MEDICATIONS** you take (Including vitamins, herbal supplements, & over the counter medications)

_____

_____

_____

_____

If patient is a Child are they on Fluoride Pills? Yes No

Have you ever been admitted to a hospital or needed emergency care during the past two years? Yes No

If yes Please explain _____

Are you allergic to or have you had an unusual reaction to any drug or latex?

_____

Are you Pregnant Yes No If so, How many months? _____

Is there a chance you may be pregnant? Yes No

Are You trying to get Pregnant? Yes No

Are you Nursing? Yes No

Are you taking Birth Control Medication? Yes No

Do you Smoke or Chew Tobacco? Yes No

if yes, How many per day? _____ For how many years? _____

Alcohol or Drug Dependency ? Yes No

	Yes	No		Yes	No
High or Low Blood Pressure			Bruise Easily		
Congenital Heart Disease			Stomach Problems / Ulcers		
Heart Attack/ Stroke			Joint Replacement		
Coronary Artery Disease			Radiation Treatment		
Heart Surgery/ Coronary Stints			Respiratory Problems		
Heart Murmur / Mitral Valve Prolapse			Rheumatic Fever		
Pacemaker / Arrhythmia			Sinus Problems		
Cold Sores			Liver Disease		
Dizziness / Fainting			Lymph Nodes Sore/ Enlarged		
Epilepsy or Seizures			Cancer		
Angina			Hepatitis / Jaundice		
Previous Infectious endocarditis			Syphilis / Gonorrhea		
Kidney Problems			HIV / AIDS		
Diabetes			Arthritis		
Blood transfusion			Glaucoma		
Anemia			Growths / Tumors		
Excessive Bleeding			Tuberculosis		
Asthma					

_____ _____

Signature Date

_____ _____

Provider Signature Date