New Smile Dentistry

Patient Information

Patient______________________________

Address_____________________________

City________________________________

State____________ Zip _______________

Home Phone________________________

Work Phone________________________

Mobile Phone_______________________

E-mail______________________________

SS#________________________________

Date of Birth________________________

Status:

Married____ Single ____ Divorced____

Separated____ Minor____ Partner____

Employer___________________________

Occupation_________________________

School______________________________

Employer/School Phone______________

Employer/School Address____________

____

Whom may we thank for referring you?

____

Dental Insurance

Responsible for the account____________________

Relationship to patient________________________

Insurance Co.________________________________

Subscriber's Name____________________________

Subscriber's Birthdate_________________________

Is there a Secondary Insurance_________________

Insurance Co.________________________________

Subscriber's Name____________________________

Subscriber's Birthdate_________________________

I confirm that I, and/or dependent have insurance coverage with ______________________________ and assign directly to Dr. Usita all insurance benefits.

I understand that I am financially responsible for all charges that my insurance does not cover or not paid for. I authorize the use of my signature for filing or submission of all my dental claims and pre-authorizations.

____________________________ ______________

Patient/Guardian Signature Date

____________________________ ______________

Print Patient Name Relation to Patient

Dental History

Reason for the appointment___________________

Former Dentist______________________________

City and State______________________________

Date of last Dental Cleaning__________________

Date of last Dental X-rays____________________

YES	NO	
		Bad Breath
		Bleeding Gums
		Blister/sores on mouth or lips
		Broken fillings
		Burning sensation on tongue
		Chew on one side of mouth
		Clicking or popping jaw
		Dry Mouth
		Finger Nail Biting
		Food entrapment between teeth
		Grinding teeth
		Gums swollen or tender
		Jaw pain
		Lip or cheek biting
		Loose teeth
		Mouth Breathing
		Orthodontic treatment
		Pain around the ear
		Periodontal treatment
		Sensitivity:
		Cold
		Hot
		Sweets

How often do you brush?___________________

How often do you floss?____________________

Health History

Physician's Name_____________________________

Date of last visit_____________________________

YES	NO	
		AIDS /HIV
		Anemia
		Anxiety Attacks
		Arthritis, Rheumatism
		Artificial Heart Valves
		Artificial Joints
		Asthma
		Back Problems
		Bleeding Abnormally with Extraction or Surgery
		Blood Disease
		Cancer _______________
		Chemical Dependency
		Chemotherapy
		Circulatory Problems
		Congenital Disease
		Contact Lenses
		Cortisone Treament
		Cough, persistent or bloody
		Diabetes
		Emphysema
		Epilepsy
		Eye Surgery
		Fainting or dizziness
		Glaucoma
		Headaches or Migraines
		Heart Murmur
		Heart Problems
		Hepatitis Type _________

Herpes
High Blood Pressure
Jaudince
Kidney Disease
Liver Disease
Low Blood Pressure
Mitral Valve Prolapse
Nervous Problems
Pacemaker
Psychiatric Care
Radiation Treatment
Respiratory Disease
Rheumatic Fever
Scarlet Fever
Shortness of Breath
Sinus Trouble
Skin Rash
Special Diet
Stroke
Swollen feet or ankles
Swollen Neck Glands
Thyroid Problems
Tonsillitis
Tuberculosis
Tumor on the head or neck
Ulcer
Unexplained weight loss
Venereal Disease

Women:

Are you taking birth control pills?_______

Are you pregnant? _________

Due Date________________

Are you nursing?__________

Medications

____

____

____

Allergies

Aspirin
Barbiturates
Codeine
Iodine
Latex
Local Anesthetic
Penicillin
Sulfa
Other _______________________