

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

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

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 Treatment
		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

Medications

Allergies

Aspirin
Barbiturates
Codeine
Iodine
Latex
Local Anesthetic
Penicillin
Sulfa
Other _____

Women:

Are you taking birth control pills? _____

Are you pregnant? _____

Due Date _____

Are you nursing? _____