Dental - Adult New Patient

Patient Information	
Patient Name	
Gender	Male Female
SSN	
DOB	
DL#	
patient home address	
patient state	
patient zip	
Patient Primary Phone #	
Primary Phone type	Home Cell
Patient Secondary Phone #	
Secondary Phone Type	Home Cell Other
Patient E-mail	
Patient Employer	
Patient Occupation	
Spouse/Emergency Contact Information	
Spouse/Emergency Marital Status	Single Married Divorced Widowed Significant Other
Emergency Name	
Emergency Contact Name	
Emergency Phone #	
Emergency Relation	
Emergency Address	
Emergency City	
Emergency State	
Emergency Zip	
Person(s) OK to release appointment or medically related information to concerning you.	
Emergency relation	
Insurance Information	
Pri. Ins. Company	
Pri. Ins. Phone #	
Pri. Ins. Group #	
Pri. Ins. Policy #	
Pri. Ins. Member ID #	
Pri. Ins. Policy Holder’s Name	
Pri. Ins. Relation	
Pri. Ins. Policy Holders SSN	
Pri. Ins. Policy Holder’s DOB	
Pri. Ins. Employer	
Pri. Ins. Work Phone #	
Pri. Ins. co-pay	

Pri. Ins. Deductible	
Sec. Ins. Company	
Sec. Ins. Phone #	
Sec. Ins. Group #	
Sec. Ins. Policy #	
Sec. Ins. Member ID #	
Sec. Ins. Policy Holders Name	
Sec. Ins. relation	
Sec. Ins. Policy Holder's SSN	
Sec. Ins. Policy Holder's DOB	
Sec. Ins. Employer	
Sec. Ins. Work Phone #	
Sec. Ins. Co-pay	
Sec. Ins. Deductible	

Dental History

How did you hear about our Practice?	Ad Internet Family or Friend Physician Other
Name of person referring	
Have your tonsils or adenoids been removed?	Yes No
Have you ever experienced jaw joint pain/discomfort (TMJ/TMD)?	Yes No
Do you have any missing or extra permanent teeth?	Yes No
Have you ever had an injury to	Teeth Mouth Chin
Do you have speech problems?	Yes No
If so, explain	
Do your gums bleed?	Yes No
Do you smoke?	Yes No
Do you like your smile?	Yes No
Do you currently or have you ever had any of the following habits	Clenching/Grinding Teeth Lip Sucking/Biting Mouth Breathing Nail biting Thumb/ Finger Sucking Chewing/Eating Problems

Medical History

Are you currently being treated by a physician?	Yes No
Reason	
Physician	

Medical Last Visit	
Phone	
Do you have any allergies/sensitivities to medications or latex?	Yes No
If yes, please list allergies	
Are you currently taking any prescription or over-the-counter medications?	Yes No
dosage	
fen-phen	Yes No
Have you had any serious illnesses or operations? If yes, describe	
Have you ever had a blood transfusion?	Yes No
If yes, give approximate dates	

(Women)

Are you pregnant?	Yes No
Nursing?	Yes No
Taking birth control pills?	Yes No

Check if you have or have ever had any of the following	Anemia Arthritis, Rheumatism Artificial Heart Valves Artificial Joints Asthma Back Problems Blood Disease Cancer Chemical Dependency Chemotherapy Circulatory Problems Cortisone Treatments Cough, Persistent Coughing Blood Diabetes Epilepsy Fainting Glaucoma Headaches Heart Murmur Heart Problems Hemophilia Hepatitis High Blood Pressure HIV/AIDS Jaw Pain Kidney Disease Liver Disease Mitral Valve Prolapse Pacemaker Radiation Treatment Respiratory Disease Rheumatic Fever Scarlet Fever Shortness of Breath Skin Rash Stroke Swelling of Feet or Ankles Thyroid Problems Tobacco Habit Tonsillitis Tuberculosis Ulcer Venereal Disease

Authorization

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my medical status. I hereby authorize the release of any information pertaining to my medical treatment necessary to process any insurance claims. I further authorize the application for benefits on my behalf for covered services and payment of any benefits to the office. I understand that I am responsible for any amount not covered by insurance. I understand that where appropriate, credit bureau reports may be obtained.

Signature
Date