New Patient Info and Medical History

1. Please enter your information.

First Name: _____ Middle Initials: _____ Last Name: _____ Date of Birth: _____

Gender:
○ Female ○ Male

Marital Status:
○ Single ○ Married ○ Domestic Partner ○ Separated ○ Divorced ○ Widowed

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

_____ Mobile Phone: _____ Home Phone: _____

Work Phone: _____ Email: _____

Preferred contact method:
○ Mobile Phone ○ Home Phone ○ Work Phone ○ Email

2. How did you learn about our practice or whom may we thank for referring you?

_____

_____

_____

_____

3. If you weren't referred, how did you hear about our office?

_____

_____

_____

_____

4. Reason for today's visit (your primary concern):

_____

_____

_____

_____

5. Level of anxiousness about visiting the dentist:

1 = None / 5 = Uncomfortable / 10 = Hiding under the bed
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

If greater than 3, please share your feelings:

_____

6. Is there anything else you would like us to know before your visit?:

7. Who is responsible for your account and payment? (if different from previous listing)

Name: Address:

Apt. / Unit #: Birthdate: Phone Number:

Email:

8. Primary Dental Insurance

Insurance company: Phone # Subscriber's Social Security #

Group #: ID#: Whose name is this insurance under?

Employer offering this insurance? Phone: Address:

9. Secondary Dental Insurance

Insurance company: Phone # Subscriber's Social Security #

Group #: ID#: Whose name is this insurance under?

Employer offering this insurance? Phone: Address:

10. Date of last dental care visit: Date of last dental x-rays: Former dentist's name: Phone #:

11. Check if you have any problem with the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Sensitivity to any of the following: cold, hot, sweets
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Food collection between certain teeth
- ☐ Sensitivity when biting
- ☐ Sores or growth in your mouth
- ☐ Grinding teeth

12. How often do you floss? _____

How often do you brush? _____

13. Your physician: _____

Date of last visit: _____

14. Have you had any serious illnesses or operations? If yes, please describe.

_____

_____

_____

_____

15. Women

Are you pregnant?
○ Yes ○ No

Are you nursing?
○ Yes ○ No

Are you taking birth control?
○ Yes ○ No

16. Check if you have or have had any of the following:

- ☐ Anemia
- ☐ Artificial joints, pins, etc.
- ☐ Blood disease
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Pacemaker
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Tobacco use
- ☐ Ulcer
- ☐ Arthritis, rheumatism
- ☐ Asthma
- ☐ Cancer
- ☐ Circulatory problems
- ☐ Epilepsy
- ☐ Headaches
- ☐ Hemophilia
- ☐ HIV AIDS
- ☐ Liver disease
- ☐ Radiation treatment
- ☐ Scarlet fever
- ☐ Swelling of feet or ankles
- ☐ Tonsillitis
- ☐ Artificial heart valves
- ☐ Bleeding abnormally
- ☐ Chemical dependency
- ☐ Congenital heart lesions
- ☐ Fainting
- ☐ Heart murmur
- ☐ Hepatitis
- ☐ Jaw pain
- ☐ Mitral valve prolapse
- ☐ Respiratory disease
- ☐ Sexually transmitted disease
- ☐ Thyroid problems
- ☐ Tuberculosis

17. List medications you are currently taking and the correlating diagnosis:

	Medication	Diagnosis
1		
2		
3		
4		

18. Please list any allergies you may have:

	Allergy
1	
2	
3	
4	

19. Emergency contact and phone number

_____

20. Please sign and date below

_____