New Patient Acquaintance

The following information is required to enable us to provide you with the best possible care. All information is strictly private and confidential. We are happy to explain anything that you do not completely understand.

Patient information:

Title _______ Name ________________________________
First Middle Initial Last

Date of Birth ________________ SS# ___________________

____
Address City Zip Code

Email ____

Cell # ____

Home # ____________________ Work # __________________

Whom may we thank for your referral? ___________________

Whom may we contact in case of emergency?

Name ______________________ Phone __________________

Person responsible for account (if different than above):

Title _______ Name ________________________________
First Middle Initial Last

Date of Birth ________________ SS# ___________________

____
Address City Zip Code

Email ____

Cell # ____

Home # ____________________ Work # __________________

Dental Insurance:

Employee ______________________________________

Employer ______________________________________

Insurance ______________________________________

Dental group # __________________________________

Secondary Dental Insurance:

Employee ______________________________________

Employer ______________________________________

Insurance ______________________________________

Dental group # __________________________________

For children under 18 years old:

Is this your child's first visit to the dentist? Y N

Has your child ever had a bad medical/dental experience? Y N

____

Is your child involved in any of the following programs?

Please circle: *Speech therapy, special education, physical handicap*

Do you have any requests/comments that might assist us in the treatment of your child?

____

____

Medical History:

Physician ________________________ City ______________

Current therapy/problems:

____

Surgery history:

____

Have you experienced the following (please circle)?

ADHD	Alcohol/substance abuse	Anemia
Anxiety	Arthritis	Artificial Joints
Asthma	Autoimmune	Back/Neck problem
Birth Control	Blood Disorder	Breath/Emphysema
Blood Disorder	Cancer/Tumor	Chemo/Radiation
Depression	Dry Mouth	Facial Injury
Fainting	Gastric Reflux	Gastrointestinal
Hearing Issues	Heart Defect/Disease	Hepatitis
High Blood Press.	High Cholesterol	HIV/AIDS
Hormone Therapy	Kidney Disease	Liver Disease
Lupus	Migraines/headaches	Osteoporosis
Pacemaker	Respiratory problems	Seizures/Epilepsy
Sinus issues	Sleep Apnea	Steroid Therapy
STD	Stroke	Thyroid issue
Tuberculosis	Ulcers	Vision/Glaucoma

Other:

____

____

Have you ever used tobacco? Y N

Are you pregnant? Y N

Ever been told to premedicate for dental visits? Y N

Ever taken medication for osteoporosis (eg. Fosamax)? Y N

Do you snore or have trouble breathing at night? Y N

Do you have allergies to medicines or materials (eg. Latex)? Y N

Please list allergies:

____

Do you take any medications (including aspirin, vitamins?) Y N

Please list on the back of this page ->

Dental History:

When was your last dental visit? _________________________

Dentist _______________________City __________________

Have you had braces/Invisalign/orthodontics? Y N

Have you had periodontal/gum treatment? Y N

Do your gums bleed after brushing/flossing? Y N

Are your teeth sensitive to *Hot Cold Pressure Sweets*? Y N

Does food catch between/around any teeth? Y N

Do you have any growths or sores in or around your mouth? Y N

Do you grind or clench your teeth? Y N

Do you have a denture or partial denture? Y N

Do you have mouth guards or retainers? Y N

Any difficulty reclining in the dental chair? Y N

Ever had difficult opening your mouth wide? Y N

Are you happy with the appearance of your teeth? Y N

What improvements would you like to see?

____

Is there anything that would make your visits more comfortable?

____

I certify that the information is correct to the best of my knowledge.

Patient signature ______________________________

(or parent/guardian) Date ____________________

Page 2/2 Please list all medical conditions you have and, in the next column, the medication(s) you are prescribed to take for this condition. Please include any over-the-counter medications (eg. aspirin, vitamins, herbals) that you take regularly. Then list the physician who prescribes this particular drug for you. Thank you so much, as this helps us better understand and protect your health.

Date	Medical Condition	Medication Prescribed	Physician

For office use:

Updated	By (initial)	Updated	By (initial)	Updated	By (initial)	Updated	By (initial)