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Family and Cosmetic Dentistry

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Adult - New Patient Paperwork

Patient Information

Patient Name: _____ Birthdate: _____ Age: _____ SS#: _____

Address: _____ Email: _____

Home #: _____ Cell #: _____ Marital Status: ◯ Married ◯ Single ◯ Widowed ◯ Divorced ◯ Separated

Employer: _____ Work #: _____ Occupation: _____

Emergency Contact: _____ Relation: _____ Phone: _____

HOW DID YOU HEAR ABOUT US? _____

Primary Dental Insurance

Insurance Co. Name: _____ Insurance Co. Phone #: _____

Policy #: _____ Group #: _____ Plan #: _____

Subscriber's Name: _____ Relationship to Patient: _____ Subscriber's DOB: _____

Subscriber's Social Security #: _____ Subscriber's Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____ Insurance Co. Phone #: _____

Policy #: _____ Group #: _____ Plan #: _____

Subscriber's Name: _____ Relationship to Patient: _____ Subscriber's DOB: _____

Subscriber's Social Security #: _____ Subscriber's Employer: _____

Dental History

Date of last dental visit: _____ What was completed during your last visit? _____

Have you ever been treated for Periodontal Disease? If yes, please explain. _____

Do you have any dental problems that you are aware of now? If yes, please describe. _____

Do you feel nervous about dental treatment? If yes, what is your biggest concern? _____

I WOULD LIKE MORE INFORMATION ABOUT: ☐ Orthodontics ☐ Veneers ☐ Whitening ☐ Implants ☐ Bridges ☐ Crowns ☐ Oral Surgery ☐ Dentures

ARE ANY OF YOUR TEETH SENSITIVE TO: Hot or cold? ◯ YES ◯ NO Sweets? ◯ YES ◯ NO Biting or Chewing? ◯ YES ◯ NO

Have you noticed any loose teeth? ◯ YES ◯ NO Do you frequently get cold sores? ◯ YES ◯ NO Do your gums bleed? ◯ YES ◯ NO

Do you frequently get oral ulcers? ◯ YES ◯ NO Have you noticed any mouth odors or bad taste? ◯ YES ◯ NO

DO YOU:	**YES**	**NO**
Clench or grind your teeth while awake or asleep? Have tired jaws, especially in the morning?	◯	◯
Have pain in the jaw joint area and/or experience clicking or popping of the jaw?	◯	◯
Have difficulty in opening and closing your mouth?	◯	◯
Have headaches, neck aches, or shoulder aches frequently?	◯	◯
Snore loudly (louder than talking or loud enough to be heard through closed doors)?	◯	◯
Often feel ***tired***, fatigued, or sleepy during daytime?	◯	◯
Has anyone observed you stop breathing during sleep?	◯	◯
Have or are you being treated for high blood pressure?	◯	◯
*If you answered **yes** to 3 or more questions above, Have you had a **sleep study**?*	◯	◯

- If yes, when was your study performed and what were the results? _____

Medical History

Physician's Name: _____ Office Phone #: _____

Are you currently taking any **prescription or over-the-counter drugs**? ◯ YES ◯ NO - If yes, please list: _____

_____

Have you been hospitalized or had a serious illness within the past **5** years? ◯ YES ◯ NO - Explain: _____

_____

Have you even taken medication to strengthen bone for conditions such as osteoporosis, multiple myeloma, Paget's disease, breast or prostate cancer? ◯ YES ◯ NO - Explain: _____

Do you use tobacco products? ◯ YES ◯ NO - If yes, what type and how much per day? _____

Do you drink alcohol? ◯ YES ◯ NO – If yes, how much and at what frequency? _____

CHECK ANY OF THE FOLLOWING WHICH YOU HAVE AT THE PRESENT OR HAVE HAD IN THE PAST:

☐ **ACID REFLUX**	☐ **AIDS/HIV**	☐ **ANGINA PECTORIS**	☐ **ASTHMA**
☐ **ARTIFICIAL HEART VALVE**	☐ **ARTHRITIS**	☐ **BRONCHITIS**	☐ **CHEMOTHERAPY**
☐ **DIABETES – TYPE - _____**	☐ **EMPHYSEMA/COPD**	☐ **EPILEPSY/SEIZURES**	☐ **FREQUENT HEADACHES**
☐ **HEART DISEASE/ATTACK**	☐ **HEPATITIS: TYPE - _____**	☐ **HIGH BLOOD PRESSURE**	☐ **JOINT REPLACEMENTS**
☐ **KIDNEY PROBLEMS**	☐ **LIVER PROBLEMS**	☐ **LOW BLOOD PRESSURE**	☐ **OSTEOPOROSIS**
☐ **PACE MAKER**	☐ **RADIATION THERAPY**	☐ **STROKE TIA**	☐ **THYROID PROBLEMS**
☐ **TUBERCULOSIS**	☐ **HBPV**	☐ **SINUS PROBLEMS/ALLERGIES**	☐ **ULCERS/COLITIS**

☐ **PREMED NEEDED FOR CLEANINGS** ☐ **SLEEP APNEA – YEAR DIAGNOSED? _____ AND** Do you currently use a CPAP? _____

HAVE ANY OF THE FOLLOWING CAUSED ALLERGIES/ADVERSE REACTIONS:

PENICILLIN	◯ YES ◯ NO	**TETRACYCLINE**	◯ YES ◯ NO	**ERYTHROMYCIN**	◯ YES ◯ NO	**SULFA**	◯ YES ◯ NO
CODEINE	◯ YES ◯ NO	**VALIUM**	◯ YES ◯ NO	**BARBITURATES**	◯ YES ◯ NO	**LATEX**	◯ YES ◯ NO
RED DYE	◯ YES ◯ NO	**ASPIRIN**	◯ YES ◯ NO	**LOCAL ANESTHETICS**	◯ YES ◯ NO	**NSAID/ADVIL/MOTRIN**	◯ YES ◯ NO

FEMALE PATIENTS:

ARE YOU PREGNANT NOW? ◯ YES ◯ NO **PRACTICING BIRTH CONTROL?** ◯ YES ◯ NO **PLAN TO BECOME PREGNANT?** ◯ YES ◯ NO

Any medical history not listed above? Please explain: _____

Authorization

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of changes in my medical status. I do hereby authorize and request for myself or the above named patient, dental services and/or whatever procedures the doctor may deem necessary. I also authorized the administration of those local anesthetic or pre-medications which may be deemed advisable. I understand and agree that it is also my responsibility to inform this office of any changes in my insurance coverage. I understand that payment is due at the time services are rendered.

_____ _____ _____

Patient or Responsible Party's Signature **Print Patient or Responsible Party's Name** **Date**