NEW PATIENT INFORMATION

WELCOME! Completion of this form enables us to better serve you. If you have any questions, please ask. We are here to help!

Patient: Mr. / Mrs. / Ms. _____ Prefer to be called:_____
Last First Middle

Home Address:_____City:_____State:_____Zip:_____

SSN: _____-_____-_____ DL#:_____ State:_____ Date of Birth_____

Phone: Home:_____ Work:_____(ext)_____ Cell:_____

Best time and number to reach you: _____

E-Mail Address: _____

Employer: _____ #of years_____ Occupation: _____

Other family members seen by us: _____

Spouse/Parent Name: _____ Employer: _____ Work #:_____

Who may we thank for referring you:_____

DENTAL INSURANCE INFORMATION

Insurance Co.: _____ Ins Phone #: _____
Insurance Claim Address: _____
Insured's Name: _____ Relationship to patient: _____
Insured's Date of Birth: _____ Insured's ID: _____

Payment is expected as services are rendered unless prior arrangements have been approved.
Your appointment time has been reserved especially for you. There will be a minimum $45.00 fee for any appointment missed or cancelled without 48 hours advance notice.

MEDICAL HISTORY

Previous Dentist:_____ Phone #: _____ Last Visit:_____

Physician's Name: _____ Phone #: _____

Current physical health is: ___Good ___ Fair ___ Poor Are you currently under a doctor's care? __Yes __No

If yes, please explain:_____

Are you currently taking medications? __Yes __ No If yes, please list all: _____
_____

Have you ever had any of the following diseases or medical problems? (Please circle all that apply)

Heart/Blood Problems	Congenital Heart Defect	Anemia	Lung Problems
Heart Attack/Stroke	Mitral Valve Prolapse	Blood Transfusion	Asthma
High Blood Pressure	Hemophilia	Abnormal Bleeding	Liver Problems
Low Blood Pressure	Heart Murmur	Rheumatic/Scarlet Fever	HIV/AIDS
Epilepsy/Seizures	Radiation/Chemotherapy	Diabetes	Migraines
Fainting/Dizzy Spells	Artificial Joint/Valve	Alcohol/Drug Abuse	Hepatitis

Please list any serious medical conditions that you've had: _____
Please list all drugs you are allergic to:_____

EMERGENCY INFORMATION

In case of emergency, whom should we contact? _____ Relationship:_____
Phone: Home:_____ Work:_____(ext)_____ Cell:_____

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 confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.
Signed: _____ Date:_____