

Welcome To Our Practice

NEW PATIENT INFORMATION FORM

First Name: _____ Last Name: _____

Date of Birth: _____ Marital Status: _____

Address: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

How do you prefer to be contacted? Cell Home Phone Email Work Phone:

Who do we call in case of emergency? Name: _____ Phone: _____

Who can we thank for referring you (how did you find out about our practice)?:

Patient: _____ (Relationship) _____ Website

Online / Google Search News Paper Ad Walk by External Signage

Social Media

Personal History

It is important to us that we meet your needs and address your primary concerns therefore we ask you to share the following information leading into your appointment today:

What is your primary concern today: _____

When did this become a concern: _____

How would you describe your last dental experience: _____

What prevented you from returning to your former Dentist?: _____

I routinely see my dentist every: 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

Do you have or have you ever had ever have Braces, Orthodontics, Treatment or Upper Bite Adjustment?: Yes No

Please answer Yes or No to the following:

YES **NO**

Gum and Bone

- Do your gums bleed or are they painful when brushing or flossing? _____
- Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____
- Is there anyone with a history of periodontal disease in your family? _____
- Have you ever experienced gum recession? _____
- Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____

Tooth Structure

- Have you had any cavities within the past 3 years? _____
- Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____
- Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____
- Do you frequently get food caught between any teeth? _____

Smile Characteristics

- 33. Is there anything about the appearance of your teeth that you would like to change? _____
- 34. Have you ever whitened (bleached) your teeth? _____
- 35. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____
- 36. Have you been disappointed with the appearance of previous dental work? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Your Privacy is Always Assured

Privacy of our patient’s personal information is important to us. Personal information is necessary for providing professional oral health care services to you and information necessary to administer your dental treatment.

I authorize communication of this personal information by mail, electronic and verbal means. Personal information includes clinical records, X-rays, study models, photographs of you and your teeth, mouth, smile and face, and general health information obtained from a medical history review, insurance information, phone numbers and email addresses. Clinical information and photographs, x-rays may also be used for long-term follow-up and research purposes, as well as for education or teaching purposes.

Your personal information will only be shared with those who have a need to know and specific information disclosed shall be restricted to only that information relevant to the recipients need to know. Those who have a need to know include referring dentists, other dental specialists, physician(s), dental laboratories and insurance carriers.

I certify that I have read and understand this document.

Signature/Parent or Guardian: _____

Date: _____

Signature/Parent or Guardian: _____

Date: _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? Excellent Good Fair Poor

Have you been instructed to take pre-medication prior to dental treatment? _____

Do You Have or Have You Ever Had:	YES	NO		YES	NO
1. hospitalization for illness or injury	<input type="checkbox"/>	<input type="checkbox"/>	20. thyroid, parathyroid disease, or calcium deficiency	<input type="checkbox"/>	<input type="checkbox"/>
2. an allergic reaction to:	<input type="checkbox"/>	<input type="checkbox"/>	21. hormone deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine			22. high cholesterol or taking statin drugs _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> penicillin			23. diabetes (HbA1c = _____) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> erythromycin			24. stomach or duodenal ulcer _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> tetracycline			25. digestive disorders _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> sulfalocal			(i.e. celiac disease, gastric reflux)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> anesthetic			26. osteoporosis/osteopenia _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> fluoride			(i.e. taking bisphosphonates)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> metals (nickel, gold, silver, _____)			27. arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> latex			28. autoimmune disease _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> other _____			(i.e. rheumatoid arthritis, lupus, scleroderma)	<input type="checkbox"/>	<input type="checkbox"/>
3. heart problems, or cardiac stent within the last six months _____	<input type="checkbox"/>	<input type="checkbox"/>	29. glaucoma _____		
4. history of infective endocarditis _____	<input type="checkbox"/>	<input type="checkbox"/>	30. contact lenses _____	<input type="checkbox"/>	<input type="checkbox"/>
5. artificial heart valve, repaired heart defect (PFO) _____	<input type="checkbox"/>	<input type="checkbox"/>	31. head or neck injuries _____	<input type="checkbox"/>	<input type="checkbox"/>
6. pacemaker or implantable defibrillator _____	<input type="checkbox"/>	<input type="checkbox"/>	32. epilepsy, convulsions (seizures) _____	<input type="checkbox"/>	<input type="checkbox"/>
7. orthopedic implant (joint replacement) _____	<input type="checkbox"/>	<input type="checkbox"/>	33. neurologic disorders _____	<input type="checkbox"/>	<input type="checkbox"/>
8. rheumatic or scarlet fever _____	<input type="checkbox"/>	<input type="checkbox"/>	(ADD/ADHD, prion disease)	<input type="checkbox"/>	<input type="checkbox"/>
9. high or low blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	34. viral infections and cold sores _____		
10. a stroke (taking blood thinners) _____	<input type="checkbox"/>	<input type="checkbox"/>	35. any lumps or swelling in the mouth _____	<input type="checkbox"/>	<input type="checkbox"/>
11. anemia or other blood disorder _____	<input type="checkbox"/>	<input type="checkbox"/>	36. hives, skin rash, hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	<input type="checkbox"/>	<input type="checkbox"/>	37. STI / STD / HPV _____	<input type="checkbox"/>	<input type="checkbox"/>
13. emphysema, shortness of breath, sarcoidosis _____	<input type="checkbox"/>	<input type="checkbox"/>	38. hepatitis (type _____) _____	<input type="checkbox"/>	<input type="checkbox"/>
14. tuberculosis, measles, chicken pox _____	<input type="checkbox"/>	<input type="checkbox"/>	39. HIV / AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
15. asthma _____	<input type="checkbox"/>	<input type="checkbox"/>	40. tumor, abnormal growth _____	<input type="checkbox"/>	<input type="checkbox"/>
16. breathing or sleep problems _____	<input type="checkbox"/>	<input type="checkbox"/>	41. radiation therapy _____	<input type="checkbox"/>	<input type="checkbox"/>
(i.e. sleep apnea, snoring, sinus)			42. biphosphonates _____	<input type="checkbox"/>	<input type="checkbox"/>
17. kidney disease _____	<input type="checkbox"/>	<input type="checkbox"/>	43. chemotherapy, immunosuppressive medication _____	<input type="checkbox"/>	<input type="checkbox"/>
18. liver disease _____	<input type="checkbox"/>	<input type="checkbox"/>			
19. jaundice _____	<input type="checkbox"/>	<input type="checkbox"/>			

- 44. emotional difficulties _____ YES NO
- 45. psychiatric treatment _____ YES NO
- 46. antidepressant medication _____ YES NO
- 47. alcohol / recreational drug use _____ YES NO

- 55. currently pregnant _____ YES NO
- 56. prostate disorders _____ YES NO

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections).

Are You:

- 48. presently being treated for any other illness _____ YES NO
- 49. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) _____ YES NO
- 50. taking dietary supplements _____ YES NO
- 51. often exhausted or fatigued _____ YES NO
- 52. experiencing frequent headaches _____ YES NO
- 53. a smoker, smoked previously or use smokeless tobacco _____ YES NO
- 54. taking birth control pills _____ YES NO

List all medications, supplements, and or vitamins taken within the last two years.

Please advise us in the future of any change in your medical history or any medications you may be taking.

Drug	Purpose	Drug	Purpose

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____