New Patient Information

Name_____ SS #_____ DOB_____

Address_____ Marital Status_____

City_____State_____Zip_____ Home Phone#_____

Work Phone #_____Cell #_____E-mail_____

Spouse or Parent's Name_____

Who may we thank for referring you to our office?_____

Emergency Contact:_____ Ph._____

Responsible Party

Name_____ Home Phone_____ Cell _____

Address_____ City_____ State_____ Zip_____

Relationship to Patient_____

Insurance Information: Primary

Name of Insured_____SS#_____DOB_____

Relationship to patient_____

Name of Employer_____ Phone_____

Address:_____City_____ State_____

Zip_____ Insurance Co._____ Group#_____

Insurance Information: Secondary

Name of Insured_____SS#_____DOB_____

Relationship to patient_____

Name of Employer_____ Phone_____

Address:_____City_____ State_____

Zip_____ Insurance Co._____ Group#_____

Please give the front desk your insurance card
(Over)

Medical History

Physician's Name_____ Ph._____ Date of Last Exam_____

Is your general health good? No Yes If No, Why?_____

_____

Have you ever had any of the following?

Joint Replacement…….....	**No**	**Yes**	**Heart Problems…….**	**No**	**Yes**
High Blood Pressure…....	**No**	**Yes**	**Diabetes…….....**	**No**	**Yes**
Bleeding/Clotting Problems	**No**	**Yes**	**Cancer…….**	**No**	**Yes**
Hepatitis A, B, or C…….	**No**	**Yes**	**Tested HIV Positive……**	**No**	**Yes**
Nervous Conditions…….	**No**	**Yes**	**Kidney Disease…….**	**No**	**Yes**
Lung Disease……	**No**	**Yes**	**Thyroid Problems……**	**No**	**Yes**
Stroke……	**No**	**Yes**	**Heart Valve Replacement**	**No**	**Yes**
Mitral Valve Prolapse…….	**No**	**Yes**	**Liver Disease……**	**No**	**Yes**
Osteoporosis…….	**No**	**Yes**	**Major Surgery…….**	**No**	**Yes**
Radiation Treatment……	**No**	**Yes**	**Chemotherapy…….**	**No**	**Yes**

WOMEN. Are You Pregnant? No Yes If Yes, Due Date_____

Please List all medications that you are currently taking._____

_____

Are you taking any blood thinner medications?_____

Do you have any drug or other allergies? No Yes If Yes, what?_____

_____

Dental History

Date of Last Exam_____ Date of Last X-Rays_____

Reason for today's visit?_____

Have you had any bad or frightening dental experiences?_____

Do you have any special dental concerns?_____

_____ _____

Signature of Patient, Parent, or Guardian Date

Welcome to Our Practice