

# New Dental Patient Form

In order to provide you the best possible Dental Care, please complete this form and bring it to your first appointment. All information is strictly **CONFIDENTIAL**.

New Patient Data			
First Name	Last Name	Date	Email*
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
* Your email will NOT be shared with any 3d parties, and is used for occasional practice announcements and promotions.			

Mailing address			
Address	City	State	Zip
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Telephone (Work)	(home)	Referred By	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Age	Birth Date	Social Security #	Number of Children
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Occupation	Employer		
<input type="text"/>	<input type="text"/>		
Marital Status	Spouse's Name	Spouse's Occupation	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Spouse's Employer	Spouse's Health Status		
<input type="text"/>	<input type="text"/>		
Emergency Contact	Phone		
<input type="text"/>	<input type="text"/>		

Current Complaints	
Describe the main purpose of your visit:	
<input type="text"/>	
Have you considered a smile makeover?	Have you considered Tooth Whitening?
<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
Have you ever had cosmetic dentistry?	If yes, describe?
<input type="radio"/> No <input type="radio"/> Yes	<input type="text"/>
Are you currently experiencing dental pain?	If yes, describe:
<input type="radio"/> No <input type="radio"/> Yes	<input type="text"/>

Insurance Information	
Name of party responsible for payment	Phone
<input type="text"/>	<input type="text"/>
Do you have dental insurance?	Name of company
<input type="radio"/> No <input type="radio"/> Yes	<input type="text"/>

Signatures	
Name of the insured _____	
I understand and agree that dental insurance policies are an arrangement between an insurance carrier _____ and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.	
Patient's signature _____	Date _____
Spouse's or guardian's signature _____	Date _____

## Medical History

Have you been treated for any conditions in the last year?

No  Yes

If yes, please describe

Date of last physical exam

Is there a chance that you are pregnant?

No  Yes

Have you had X-rays taken?

No  Yes

If Yes, where?

What medications are you taking and for what conditions (Please list dosage and amounts,

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency).

## Family History

**Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)**

## Misc Pain and Symptoms

Do you experience dental pain every day?

No  Yes

Do your symptoms interfere with daily life?

No  Yes

Do you grind your teeth at night?

No  Yes

Does hot or cold cause pain in your teeth?

No  Yes

Habits	None	Light	Moderate	Heavy
Alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Coffee	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tobacco	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drugs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Appetite	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Soft Drinks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Water	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Salty Foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sugary Foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Artificial Sweeteners	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>