NEW PATIENT FORM

Patient Name: _____ Date: _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child

Social Security # _____ Date of Birth: _____

Cell # _____ Home#_____ Work#_____

Address: _____
Street City State Zip Code

Email: _____

Health Information

Date of Last Dental Visit: _____

Do you have or have you ever had any of the following? Please check all that apply:

☐ Anemia	☐ Drug Allergies	☐ Heart Murmur	☐ Organ Transplant	☐ Sleep Apnea
☐ Artificial Joints	☐ Epilepsy	☐ Hepatitis	☐ Osteoporosis	☐ CPAP
☐ Asthma	☐ Excessive Bleeding	☐ High Blood Pressure	☐ Other Allergies	☐ Oral Appliance
☐ Blood Disease	☐ Fainting	☐ HIV/AIDS	☐ Pacemaker	☐ STD
☐ Cancer	☐ Glaucoma	☐ Kidney Disease	☐ Radiation Treatment	☐ Stroke
☐ Dental Anxiety	☐ Head Injuries	☐ Latex Allergy	☐ Respiratory Problems	☐ Tuberculosis
☐ Diabetes	☐ Heart Disease	☐ Mental Disorders	☐ Sinus Problems	

Do you have any health problems needing further clarification? _____

Are you pregnant? ☐ Yes ☐ No Due Date: _____

Name of Primary Care Physician: _____Phone # _____

List all medications you are currently taking (including over the counter & supplements):

_____

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

Have you taken or are you now taking any illicit (recreational) drugs? _____

Do you own a retainer or a night guard? ☐ Yes ☐ No How often do you wear them?_____

To the best of your knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor/staff at the next appointment without fail.

Signature of patient or guardian _____ **Date**_____

Insurance Information

Policy Holder Name: _____ Is Policy Holder a Patient? ☐Yes ☐No
Policy Holder Date of Birth: _____ Subscriber ID# _____
Group # _____ Insurance Phone # _____
Policy Holder's Address: _____
Street City State Zip Code
Policy Holder's Employer:_____ Relationship to Patient ☐Self ☐ Spouse ☐Child

Insurance Plan's Name: _____
Insurance Address: _____

Responsible Party Information

Name: _____ ☐Male ☐Female Relationship to patient _____
Social Security # _____ Date of Birth: _____
Phone (Home) _____ (Work) _____ (Cell) _____
Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

Employer Name: _____ Occupation: _____
Address: _____
Street City State Zip Code

Referral Information

Whom may we thank for referring you to our practice?
☐ Another Patient ☐ Internet/Website ☐Insurance ☐Signage/Walk In

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred during their care. Financial responsibility of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he/she is personally responsible for payment of all dental services. This office will help file patients insurance and will credit any such collections to the patients account. **However, the dental office cannot render services on the assumption that our charges will be paid by an insurance company.** I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination. I grant my permission to you to release any information needed by my insurance company. **I have read the above conditions of treatment and agree to their content.**

Signature of Patient or Guardian _____ **Date** _____
Relationship to Patient _____