

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

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 \_\_\_\_\_