New Patient Form

Patient Information

First Name: ______________ Middle Initial: ______ Last Name: ______________ Suffix: ______

Street: ______________ City: ______________ State: ______ Zip: ______

Home Phone #: ______________ Mobile #: ______________ SSN: ______________

Email Address: ______________

Date of Birth: ______________ Sex: ☐ Female ☐ Male ☐ Unspecified

Emergency Contact: ______________ Emergency Phone #: ______________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other: ______________

Responsible Party

First Name: ______________ Middle Initial: ______ Last Name: ______________ Suffix: ______

Street: ______________ City: ______________ State: ______ Zip: ______

Home Phone #: ______________ Mobile #: ______________ SSN: ______________

Responsible Party Signature: ______________ Date: ______________

Date of Birth: ______________ Sex: ☐ Female ☐ Male ☐ Unspecified

Preferred Pharmacy

Name: ______________ Phone Number: ______________

Street: ______________ City: ______________ State: ______ Zip: ______

Primary Dental Insurance

Is subscriber the same as patient? ☐ Yes ☐ No

Subscriber Information:

First Name: ______________ Last Name: ______________ Date of Birth: ______________

Employer Name: ______________ Insurance Company: ______________

Subscriber ID: ______________ Group #: ______________ Subscriber SSN: ______________

Relationship to Subscriber: ☐ Spouse ☐ Child ☐ Other: ______________

Secondary Dental Insurance (if applicable)

Is subscriber the same as patient? ☐ Yes ☐ No

Subscriber Information:

First Name: ______________ Last Name: ______________ Date of Birth: ______________

Employer Name: ______________ Insurance Company: ______________

Subscriber ID: ______________ Group #: ______________ Subscriber SSN: ______________

Relationship to Subscriber: ☐ Spouse ☐ Child ☐ Other: ______________

(Please Turn Page Over)

Health History

Reason for Visit: ______________________________

Are you under the care of a primary physician? ☐ Yes ☐ No

Primary Physician's Name: ______________________ Physician Phone #: ______________________

Approximate Date of Last Physical: ______________________

Are you taking or have you taken any steroid/cortisone therapy in the last 2 years? ☐ Yes ☐ No

Have you ever been hospitalized? ☐ Yes ☐ No

Are you taking or have you taken Oral Bisphosphonates (e.g. FOSAMAX, BONIVA) or IV Bisphosphonates, (e.g. ZOMETA, AREDIA)?

☐ Yes ☐ No

Do you require antibiotics prior to dental procedures? ☐ Yes ☐ No

Are you allergic or have you had an adverse reaction to any of the following?

☐ **None** ☐ Amoxicillin ☐ Aspirin ☐ Epinephrine ☐ Latex

☐ Metals ☐ Novocain ☐ Penicillin ☐ Sulfa ☐ Tetracycline ☐ Other: ______________________

List any medications you are taking including non-prescription drugs and herbals/vitamins:

☐ **None**

____

____

Do you use tobacco (smoking, snuff, Chew, vape)? ☐ Yes ☐ No

Do you use controlled substances (including marijuana)? ☐ Yes ☐ No

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Check any conditions that apply to you:

☐ **NONE**

☐ Alcoholism	☐ Drug Addiction	☐ Mitral Valve Prolapse
☐ Allergies of Hives	☐ Epilepsy	☐ Mobility Impairment
☐ Anemia	☐ Excessive Bleeding	☐ NON-DENTAL Implants
☐ Arthritis	☐ Fainting/Dizziness	☐ Organ Transplants
☐ Artificial Joints/Pins	☐ Hearing Impairment	☐ Pace Maker
☐ Aspirin Therapy	☐ Heart Murmur	☐ Psychiatric Care
☐ Asthma	☐ Heart Surgery	☐ Radiation Therapy
☐ Blood Thinners	☐ Heart Trouble	☐ Tuberculosis
☐ Blood Transfusion	☐ Hepatitis	☐ Rheumatic Fever
☐ Breathing Problems	☐ High Blood Pressure	☐ Seizures
☐ Cancer	☐ HIV/AIDS	☐ Sexually Transmitted Infection
☐ Chemotherapy	☐ Kidney Disease	☐ Sinus Problems
☐ Coumadin Therapy	☐ Liver Disease	☐ Stomach Problems
☐ Dementia	☐ Lung Disease/COPD	☐ Stroke
☐ Diabetes	☐ Lupus	☐ Thyroid Disease
☐ High Cholesterol	☐ Ulcers	☐ Visual Impairment
☐ Sleep Apnea	☐	☐

COMMENTS: ______________________________

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(Please Complete Second Page)

Patient Name: ______________________________

Women Patients Only

Are you currently pregnant? ☐ Yes ☐ No Estimated Delivery Date: ____________

Are you nursing? ☐ Yes ☐ No Are you taking any birth control prescriptions? ☐ Yes ☐ No

**NOTE Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

Dental History

Approximate Date of Last Dental Visit: ____________

Approximate Date of Last Dental X-ray: ____________

Oral Health

Have you ever been treated for periodontal (gum) disease? ☐ Yes ☐ No

Have you ever had Novocaine or other local anesthetic? ☐ Yes ☐ No

How happy are you with your smile (1-10)? ____________

Are you currently wearing dentures? ☐ Yes ☐ No

Please check any conditions that apply to you below:

☐ Jaw Pain (TMJ)	☐ Teeth Grinding/Clenching	☐ Use of Tobacco Products	☐ Mouth Sores
☐ Sensitive Teeth	☐ Difficulty Chewing/Swallowing	☐ Broken/Loose Teeth	☐ Swollen/Bleeding Gums

Have you ever had orthodontic treatment? ☐ Yes ☐ No

I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge. I hereby give my consent to the dentist to perform an examination and diagnose my condition. I also give consent for any preventive, restorative or emergency procedures which may be necessary. I understand that this consent will remain in effect until treatment is terminated with by me or the

Patient Signature: ______________________ Date: ____________

Patient Name: ______________________ Date: ____________

Doctor Signature/Medical Review: ______________________ Date: ____________

dentist.

(Please Turn Page Over)

Patient Signatures

Release of Information to Insurers and Assignment of Benefits (must be signed by all patients with insurance and those who expect to obtain insurance)

To the extent permitted by law, I consent to my practice (or their designees) use and disclosure of my Protected Health Information to carry out payment activities in connection with my insurance claim. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. I further authorize and direct payment to my practice of the dental benefits otherwise payable to me. This one time authorization will remain in effect unless cancelled in writing. I further understand that I am responsible for all deductibles, copayments, denials and non-covered services. I fully understand that my specific policy is an agreement between myself and my insurance company, and I am responsible for my bill should my insurance benefits result in less coverage than

Signature: ______________________________ Date: ____________________

(If patient is a minor or disabled, the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party Section).

anticipated.

Consent to obtain patient medication history

To the extent permitted by applicable law, I authorize this dental practice (or their designees) to collect information about my prescription history from my pharmacy and insurers (as applicable) and give my pharmacy and insurers permission to disclose such information. This includes prescription information related to medicines to treat AIDS/HIV and medicines used to treat mental health issues.

Signature: ______________________________ Date: ____________________

(If patient is a minor or disabled, the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party Section).

Payment and Cancellation Policy (signed by ALL new patients)

By signing below, I understand that payment is due at the time of treatment, unless other arrangements have been made. **In the case of minor children, that parent or guardian that presents the minor for treatment is responsible for payment. We cannot bill a third party** (only 1 bill per family will be issued). Nonpayment of account may result in collection charges if your account is referred for collection purposes.

I understand that I am responsible for cancelling appointments with 24 hour notice. If appointments are missed or not cancelled with required notice, a fee may be charged.

Signature: ______________________________ Date: ____________________

(If patient is a minor or disabled, the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party Section).

Notice of Privacy Practices (signed by ALL new patients)

By signing below, I acknowledge that I have read, or was provided to opportunity to read the Notice of Privacy Practice, as mandated

Signature: ______________________________ Date: ____________________

(If patient is a minor or disabled, the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party Section).

by the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).