NEW DAY DENTISTRY

TODAYS DATE ___/___/___

Patient Information

NAME: last_____ first _____ middle initial _____ SEX : M F BIRTHDATE ___/___/__ AGE ____

IF PATIENT IS A MINOR, GIVE PARENT OR GUARDIAN NAME _____

ADDRESS: street _____ city _____ state _____ zip _____

PHONE NUMBER: home _____cell _____ work_____

EMAIL ADDRESS: _____ DRIVER'S LICENSE # _____ state _____

SPOUSE /PARTNER/GUARDIAN: name _____phone number _____

IN CASE OF EMERGENCY CONTACT: name _____ __phone number _____

OCCUPATION _____ EMPLOYER _____ phone number _____

Whom May We Thank For Referring You _____

Responsible Party Information

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT: last _____ first_____

RELATIONSHIP TO PATIENT _____ EMPLOYER _____

SOCIAL SECURITY # _____ DRIVERS LICENSE # _____ state _____

BIRTHDATE ___/___/___ PHONE NUMBER home _____ work _____

Insurance Information

PRIMARY INSURANCE

NAME OF INSURED last_____ first_____ BIRTHDATE ____/____/____

INSURANCE COMPANY _____GROUP # _____POLICY /ID # _____

SECONDARY / ADDITIONAL INSURANCE (if applicable)

NAME OF INSURED last_____ first_____ BIRTHDATE ____/____/____

INSURANCE COMPANY _____GROUP # _____POLICY /ID # _____

Medical History

		YES	NO
1.	DO YOU HAVE ANY CURRENT HEALTH PROBLEMS? If yes, please explain: _____	☐	☐
2.	ARE YOU UNDER THE CARE OF A PHYSICIAN NOW? If yes, please explain: _____	☐	☐
3.	DO YOU USE TOBACCO?	☐	☐
4.	DO YOU USE CONTROLLED SUBSTANCES?	☐	☐
5.	ARE YOU PREGNANT OR THINK YOU MAY BE?	☐	☐
6.	HAVE YOU BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLINESS WITHIN THE LAST 5 YEARS? If yes, please explain: _____	☐	☐
7.	HAVE YOU EVER TAKEN FOSAMAX, BONIVA, ACTONEL OR ANY CANCER MEDICATIONS CONTAINING BISPHOSPHONATES?	☐	☐

MEDICATION LIST
(PRESCRIPTION / OVER-THE-COUNTER)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

8. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING? CIRCLE IF APPICABLE

Local Anesthetics (e.g. Novocain)	Sulfa Drugs	Aspirin	Any Metals	Barbiturates
Penicillin / Antibiotics	Codeine	Nitrous Oxide	Latex	Sedatives

9. ARE YOU ALLERGIC TO ANY OTHER MEDICATIONS OR SUBSTANCES? If yes, please list: _____
10. PLEASE CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

Heart Disease/Attack	AIDS/HIV	Bruise Easily
Angina Pectoris (chest pain)	Hepatitis A (infectious)	Emphysema
High Blood Pressure	Hepatitis B (serum)	Tuberculosis (TB)
Heart Murmur	Liver Disease	Asthma
Rheumatic Fever	Blood Transfusion	Hay Fever
Congenital Heart Lesion	Drug Addiction	Sinus Trouble
Mitral Valve Prolapse	Hemophilia (bleeding problem)	Allergies or Hives
Artificial Heart Valve	Fever Blisters	Diabetes (type 1 or type 2)
Heart Pacemaker	Epilepsy or Seizures	Thyroid Disease
Heart Surgery	Nervousness	Radiation Treatment
Artificial Joins (hip, knee, etc)	Psychiatric Treatment	Arthritis
Anemia	Glaucoma	Cortisone Medicine
Stroke	Chemotherapy	Pain in Jaw Joints (TMJ)
Kidney Trouble	Venereal Disease	Alcoholism
Ulcers	(Syphilis, Gonorrha, etc.)	Cosmetic Surgery

11. Any other medical issue you feel that we should be aware of? _____

_____

Dental History

1. How long ago was your last visit to a dentist? _____ What was done? _____
2. Date of last complete dental examination? _____ Full set of X-Rays? _____
3. What is your reason for visiting us today? _____
4. On a scale of 1 -10, 10 being the most fearful, how much anxiety do you have about being at the dentist ? _____

	Yes	No
5. Are you having any problems with your teeth, gums, or mouth now?	☐	☐
6. Do your gums feel irritated or bleed while brushing or flossing?	☐	☐
7. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
8. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
9. Do you feel pain on any of your teeth?	☐	☐
10. Do you have any sores or lumps in or near your mouth?	☐	☐
11. Have you had any head, neck, or jaw injuries?	☐	☐
12. Have you ever felt clicking, popping or pain in your jaw joint?	☐	☐
13. Do you ever experience difficulty opening/closing your jaw or difficulty chewing?	☐	☐
14. Do you have frequent headaches, earaches, or neck pains?	☐	☐
15. Are you aware of clenching or grinding your teeth?	☐	☐
16. Have you ever had any difficult extractions or extraction complications in the past?	☐	☐
17. Have your ever had orthodontic treatment (braces) on your teeth?	☐	☐
18. Do you wear dentures or partial dentures?	☐	☐
19. Do you have discolored teeth that bother you?	☐	☐
20. Do you like your smile?	☐	☐
21. Do you floss regularly?	☐	☐

Are there any other concerns you have regarding your oral health that we should be aware of? _____

_____

_____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on by behalf or my dependents.

X _____

Signature of patient (or parent/guardian if minor) Date