

**New Patient Form** (please print clearly)

**Confidential Patient Information Part 1**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Business Phone: (\_\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ City/State: \_\_\_\_\_

Social Security No.: \_\_\_\_\_ Drivers License No.: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Marital Status (Please check one):     Minor     Single     Married  
    Divorced     Widowed     Separated

Do you have dental insurance?     Yes     No

Do you have secondary insurance?     Yes     No

Person to contact in case of emergency: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Whom may we thank for referring you?: \_\_\_\_\_

**Responsible Party** (if other than above name patient)

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Business Phone: (\_\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

## Confidential Patient Information Part 2

Chief Dental Complaint: \_\_\_\_\_

Date of last dental exam and/or cleaning: \_\_\_\_\_

Name of the Physician: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

1. Are you under medical treatment now?  Yes  No

If yes, explain \_\_\_\_\_

2. Have you ever been hospitalized for any surgical operation or serious illness?  Yes  No

If yes, explain \_\_\_\_\_

3. Are you taking any medication including nonprescription medicine?  Yes  No

If yes, please list all \_\_\_\_\_

4. Do you use (check all that apply):  tobacco?  alcohol?  other drugs?

5. Are you wearing contact lenses?  Yes  No

6. Are you allergic to or have you had any reactions to the following:

Local anesthetics	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Barbiturates	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Penicillins	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sedatives	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other antibiotics	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Lodine	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Please list _____			Aspirin	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sulfa drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other: _____		

7. Do you have or have you had any of the following?

High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Radiation Therapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cardiac Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fainting/Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Low Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Epilepsy/Convulsions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kidney Diseases	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Joint Replacement/Implant	<input type="checkbox"/> Yes	<input type="checkbox"/> No
AIDS or HIV Infection	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis/Jaundice	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Thyroid Problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sexually Transmitted Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chest Pains	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stomach Trouble/Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hayfever/Allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other _____		

Patient Signature \_\_\_\_\_