

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: _____

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

Check any conditions that apply to you:

NONE

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

COMMENTS: _____

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.

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").