New Patient Information

Patient

Patient's Last Name: _____ First name: _____ Initial: _____

Sex M F Date of Birth: _____/_____/_____ SSN#: _____

Home Address: _____ City, State, Zip code _____

Home Phone: ( ) _____-_____ Cell: ( ) _____-_____ Work Cell: ( ) _____-_____

Email: _____ Occupation _____

How did you hear about our office? _____

How may we help you today?_____

Parent/Guardian or Emergency Contact

Name: _____ Relationship to Patient: _____

Address: _____ City, State, Zip code _____

Home Phone: ( ) _____-_____ Cell: ( ) _____-_____ Email: _____

Physician

Patient's Physician: _____ Office Location: _____

Physicians Phone: ( ) _____-_____ Your current physical health is: Good Fair Poor

Last Seen: _____ Reason: _____ Next Appointment _____

Other physician/healthcare providers being seen: Yes No Reason: _____

Name: _____ City, State _____ _____

Dental Insurance

Subscriber Name: _____Relationship to Patient: _____

Subscriber DOB:_____/_____/_____ Subscriber SSN: _____

Subscriber Employer:_____ Insurance Company: _____

Group Number:_____ Group ID: _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have filled out this form to the best of my knowledge. I understand that I am financially responsible for all the charges whether or not paid by insurance. I hereby authorize the dentist to release all information necessary to secure the payments of benefits. I authorize this signature on all insurance submission.

Patient/Guardian Signature: _____ Date: _____

Medical History

Your answers are confidential and are for office records only.

Yes No Conditions

- ❑ ❑ Abnormal Bleeding
- ❑ ❑ ADHD
- ❑ ❑ Alcohol Abuse
- ❑ ❑ Anemia
- ❑ ❑ Arthritis or joint problems
- ❑ ❑ Artificial Heart Valve
- ❑ ❑ Asthma, sinus problems, hay fever
- ❑ ❑ Birth defects or hereditary problems
- ❑ ❑ Bone fractures or major injuries
- ❑ ❑ Cancer, tumor
- ❑ ❑ Chemotherapy or radiation therapy
- ❑ ❑ Chest pain, shortness of breath, swollen ankles
- ❑ ❑ Colitis, stomach ulcers, reflux
- ❑ ❑ Congenital Heart Defect
- ❑ ❑ Depression or mental health disturbances
- ❑ ❑ Developmental disorders
- ❑ ❑ Diabetes or low sugar
- ❑ ❑ Drug Abuse
- ❑ ❑ Endocrine or thyroid problems
- ❑ ❑ Facial Surgery
- ❑ ❑ Frequent Headaches
- ❑ ❑ Glaucoma
- ❑ ❑ HIV+ AIDS
- ❑ ❑ Heart Attack, angina, stroke
- ❑ ❑ Heart defects, heart murmur, rheumatic disease
- ❑ ❑ Heart Surgery
- ❑ ❑ Headaches or migraines
- ❑ ❑ Hepatitis, jaundice or other liver problems
- ❑ ❑ History of osteoporosis
- ❑ ❑ History of eating disorders, anorexia, bulimia
- ❑ ❑ High or Low Blood Pressure

Yes No Conditions

- ❑ ❑ frequent era infections, cold throat infections
- ❑ ❑ Injuries to head, neck, or face
- ❑ ❑ Joint Replacement
- ❑ ❑ Kidney Problems
- ❑ ❑ Mitral Valve Prolapse
- ❑ ❑ Pace Maker
- ❑ ❑ Psychiatric Problems
- ❑ ❑ Seizures, fainting, neurologic problems

❑ ❑ Sexually Transmitted Disease, Gonorrhea, Shyphilis, Herpes
❑ ❑ Tonsil or adenoid condition
❑ ❑ Tuberculosis
❑ ❑ Other _____

Yes No Allergies
❑ ❑ Aspirin
❑ ❑ Antibiotics
❑ ❑ Codeine
❑ ❑ Dental Anesthetics
❑ ❑ Erythromycin
❑ ❑ Latex
❑ ❑ Metals
❑ ❑ Penicillin
❑ ❑ Tetracycline
❑ ❑ Other _____

Yes No If Female, Please Answer
❑ ❑ Are you taking any form of Birth Control?
❑ ❑ Are you pregnant? If so, # of Weeks __
❑ ❑ Are you nursing?

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements, that you take.

Medication _____ Taken for _____
Medication _____ Taken for _____
Medication _____ Taken for _____
Have you ever taken any medications to strengthen your bones? Please describe._____ Do you or have you ever had a substance abuse problem?
_____
Do you chew or smoke tobacco? _____
Any other physical problems? _____

Dental History

Yes No Dental Condition
❑ ❑ Permanent or extra teeth removed
❑ ❑ Extra or congenitally missing teeth
❑ ❑ Any sensitivity or soreness to your teeth

❑ ❑ Foul taste or mouth odor
❑ ❑ Jaw fractures, cysts, infections
❑ ❑ Any root canal treated teeth
❑ ❑ History of Gum boils, canker sores, or cold sores
❑ ❑ History of speech problems
❑ ❑ Difficulty breathing through nose
❑ ❑ Food impaction between the teeth
❑ ❑ Mouth breathing habit or snoring at night
❑ ❑ Oral habits (eg finger or pen sucking)
❑ ❑ Tooth grinding or clenching
❑ ❑ Clicking, locking, or popping in jaw joints
❑ ❑ Soreness in jaw muscles or face muscles

Yes No Dental Conditions

❑ ❑ Ringing in ears
❑ ❑ Difficulty in chewing or opening jaw
❑ ❑ Problems in Temporomadibular joint (TMJ)
❑ ❑ Broken or missing fillings
❑ ❑ Any unfavorable dental experience in the past?
❑ ❑ Have you ever been diagnosed with gum disease or pyorrhea?
❑ ❑ Have you ever had an orthodontic consultation or orthodontic treatment in the past?
❑ ❑ Any metal rods, pins or implants placed?
❑ ❑ Do your gums bleed?
❑ ❑ Do you have gum disease?
❑ ❑ Do you get anxious with dental treatment?
❑ ❑ Other _____

What is your chief concern regarding your dental health? _____

Do you take antibiotic pre-medication before any dental procedures?_____

Have you noticed any changes in your face or jaws? _____

How often do you brush? _____How often do you floss? _____

How often do you visit the dentist? _____ Last appointment date? _____

Are you satisfied with your smile? If not, what do you want to change? _____

What is the status of your dental health? Good Fair Poor

Have your parents or siblings ever had any of the following health problems?

Bleeding Disorder Diabetes Any heart problems Asthma Gum Disease Other _____

Acknowledgement

I have read the above questions and understand them. I will not hold my dentist responsible for any errors that I have made in the completion of this form. I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform Ace Dental Center of any changes in my medical or dental status.

I authorize the release of my information regarding my dental treatment to my dental and/or medical insurance company.

Patient/Guardian Signature: _____ Date: _____