FAMILY & COSMETIC DENTISTRY

New Patient Form

WELCOME TO OUR OFFICE

About You

Today's Date (mm/dd/yy): _____

Name: _____
LAST FIRST M

Birthdate: m____/d____/y____ Marital Status: _____

Home Address: _____

City: _____ Postal Code: _____

Hm #: _____ Cell #: _____

Wk #: _____ Employer: _____

Occupation: _____

Your Email: _____

Who may we THANK for referring you: _____

If you are completing this for a child, indicate

Parent's Name responsible _____

About Your Spouse/Partner

His/Her Name: _____

Birthdate: m____/d____/y____ Cell #: _____

Employer: _____ Wk #: _____

Occupation: _____

Email: _____

Dental Insurance

YOUR DENTAL PLAN

Insurance Co. Name: _____

Insured's Name: _____

Group # (Policy #): _____ ID #: _____

Basic: _____ % Major: _____ %

Annual Limit: $ _____ Deductible: $ _____

YOUR SPOUSE'S DENTAL PLAN

Insurance Co. Name: _____

Insured's Name: _____

Group # (Policy #): _____ ID #: _____

Basic: _____ % Major: _____ %

Annual Limit: $ _____ Deductible: $ _____

Dental History

1. Do you have any dental discomfort or concerns? ❑ Yes ❑ No
   If yes, please explain _____
2. Are any teeth sensitive to hot, cold, sweets or chewing? ❑ Yes ❑ No
3. Do your gums bleed when brushing or flossing them? ❑ Yes ❑ No
4. Do you grind or clench your teeth? ❑ Yes ❑ No
5. Do you hear "popping" or "clicking" sounds from your jaw joints? ❑ Yes ❑ No
6. Are you aware of any swelling or lumps in your mouth? ❑ Yes ❑ No
7. If you have missing teeth, have you considered tooth replacement? ❑ Yes ❑ No
8. How often do you have a dental check-up? 6 mos ❑ 9 mos ❑ annually ❑
9. Have you ever had any dental work done? ❑ Yes ❑ No
   If yes, what procedures? _____
10. Have you ever had an unpleasant experience in a dental office? ❑ Yes ❑ No
11. When was your last dental visit? _____
12. Name of former dentist (to request records) _____
13. Are you satisfied with the colour of your fillings? ❑ Yes ❑ No
14. Would you like a whiter and brighter smile? ❑ Yes ❑ No
15. Are you unhappy with the appearance of your teeth and smile? ❑ Yes ❑ No

→

Medical History

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name: _____

Phone #: _____ Date of last visit: _____

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No

Please specify: _____

_____

Are you taking any prescription or over-the-counter drugs? ❑ Yes ❑ No

Please list _____

_____

Have you ever been:

1. Seriously ill ❑ Yes ❑ No
2. Treated with Radiation/Chemotherapy ❑ Yes ❑ No
3. Treated with Joint Replacement (knee, hip) ❑ Yes ❑ No
4. Treated with Heart Surgery ❑ Yes ❑ No

Do you smoke? ❑ Yes ❑ No

Do you take Aspirin daily? ❑ Yes ❑ No

Have you ever had any of the following diseases or medical problems (please circle):

Heart (Surgery, Disease, Attack)
Chest Pain
Heart Murmur
High/Low Blood Pressure
Rheumatic Fever
Scarlet Fever
Arthritis/Rheumatism
Swollen Ankles
Stroke
Artificial Joints (hip, knee)
Kidney Problems
Ulcers
Diabetes
Thyroid Problems
Glaucoma
Emphysema
Difficulty Breathing
Neurological Disorders
Hospitalized/Surgery Performed
Psychiatric/Psychological Care
Tuberculosis
Asthma
Hay Fever
Sinus Problems
Radiation/Chemotherapy
Cancer
Hepatitis A (infectious)
Hepatitis B (serum)
Drug/Alcohol Abuse
Venereal Disease
A.I.D.S./H.I.V. Positive
Hemophilia
Sickle Cell Disease
Bruise Easily
Liver Disease
Abnormal Bleeding
Fainting/Dizzy Spells
Nervous/Anxious
Epilepsy/Seizures
Other _____

_____

Medical History *continued*

Are you allergic to any of the following? (please circle):

Local Anaesthetic
Codeine
Penicillin or other Antibiotics
Aspirin
Sulfa Drugs
Any Metals
Barbituates
Latex Rubber
Iodine
Other _____

Women only

Are you pregnant or think you may be pregnant?

❑ Yes ❑ No Due Date: _____

Are you nursing? ❑ Yes ❑ No

Are you taking oral contraceptives? ❑ Yes ❑ No

Medical Updates

Date

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

This is to certify that I, undersigned, consent to the performing of the dental procedures agreed to be necessary or advisable, as indicated and I will assume responsibility for fees associated with those procedures.

I hereby authorize the release of information contained in claims to be submitted electronically to my insuring company plan administrator.

Your appointment time will be reserved especially for you. If you are unable to keep the appointment we will require 48 hours notice.

_____

SIGNATURE DATE

Our commitment is our dedication to both you and our profession by carrying out our services to the absolute best of our ability. Your help in making us the best is appreciated.
Remember the greatest compliment our patients can give is the referral of their friends and loved ones.