New Adult Patient

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We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can and bring with to your first appointment. If you have any questions we'll be glad to help you.

PATIENT INFORMATION

Name ____________________ Sex ☐ M ☐ F
Last Name *First Name* *Initial*

Age ________ Birth date __________ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Home Address ____________________
Street *City* *State* *Zip*

Mailing Address ____________________
Street *City* *State* *Zip*

Patient Employed by ____________________ Occupation ____________________

Home Phone ____________________ Work Phone ____________________

Email ____________________ How were you referred to us? ____________________

PRIMARY INSURANCE

Person Responsible for Account ____________________
Last Name *First Name* *Initial*

Relationship to Patient ____________________ Birth date __________ Soc. Sec. # ____________________

Address ____________________
Street *City* *State* *Zip*

Home Phone ____________________ Work Phone ____________________

Person responsible is employed by: ____________________

Occupation ____________________

Business Address ____________________

Insurance Company ____________________

Contract # ____________________ Group # ____________________ Subscriber # ____________________

Names of other dependents covered under this plan ____________________

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name ____________________

Relationship to Patient ____________________ Birth date __________ Soc. Sec. # ____________________

Address ____________________
Street *City* *State* *Zip*

Home Phone ____________________ Work Phone ____________________

Subscriber Employed by ____________________

Insurance Company ____________________

Contract # ____________________ Group # ____________________ Subscriber # ____________________

Names of other dependents covered under this plan ____________________

DENTAL HISTORY

Reason for Today's Visit ____

Dentist ____

Address ____

Date of last dental care ____________________ Date of last dental x-rays ____________________

Check if you have had problems with any of the following:

☐ Bad breath	☐ Loose teeth or broken fillings	☐ Sensitivity when biting
☐ Bleeding gums	☐ Periodontal treatment	☐ Sores or growths in your mouth
☐ Clicking or popping jaw	☐ Sensitivity to cold	
☐ Food collection between teeth	☐ Sensitivity to hot	
☐ Grinding teeth	☐ Sensitivity to sweets	

How often do you floss? ____________________ How often do you brush? ____________________

MEDICAL HISTORY

Physician Name ______________________________ Date of Last Visit ______________

Date of last physical examination ____________ Results ______________________________

Have you had any serious illnesses or injuries? ☐ Yes ☐ No If yes, describe ____________________

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates ____________________

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

HAS MINOR/CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING? IF YES, PLEASE CHECK

☐ AIDS	☐ Circulatory Problems	☐ Hepatitis	☐ Scarlet Fever
☐ Anemia	☐ Cortisone Treatments	☐ High Blood Pressure	☐ Shortness of Breath
☐ Arthritis, Rheumatism	☐ Cough, Persistent	☐ HIV Positive	☐ Skin Rash
☐ Artificial Heart Valves	☐ Cough up Blood	☐ Jaw Pain	☐ Stroke
☐ Asthma	☐ Diabetes	☐ Kidney Disease	☐ Swelling of Feet or Ankles
☐ Back Problems	☐ Epilepsy	☐ Liver Disease	☐ Thyroid Problems
☐ Blood Disease	☐ Fainting	☐ Mitral Valve Prolapse	☐ Tobacco Habit
☐ Cancer	☐ Glaucoma	☐ Nervous Problems	☐ Tonsillitis
☐ Chemical Dependency	☐ Headaches	☐ Pacemaker	☐ Tuberculosis
☐ Chemotherapy	☐ Heart Murmur	☐ Psychiatric Care	☐ Ulcer
	☐ Heart Problems	☐ Radiation Treatment	☐ Venereal Disease
	☐ Hemophilia	☐ Respiratory Disease	
		☐ Rheumatic Fever	

Medications ____

Allergies ____

AUTHORIZATION

I authorize my insurance company to pay the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature ______________________________ Date ______________

UPDATE

Has there been any change in patient's health since last dental appointment? ☐ Yes ☐ No

If yes, please describe ____

Is patient taking any new medications? ☐ Yes ☐ No

If yes, please list ____

Signature ______________________________ Date ______________

Signature of Dentist ______________________________ Date ______________

Payment is due in full at the time of treatment unless prior arrangements have been approved.