NEW PATIENT INFORMATION FORM

LAST NAME_____ **FIRST NAME**_____ **MI**_____

STREET ADDRESS_____

CITY_____ **STATE**_____**ZIP**_____**E-MAIL**_____

HOME # _____**WORK #**_____**CELL#**_____

SS#_____**BIRTHDATE**_____**MARITAL STATUS**___**SEX**___

WHO MAY WE THANK FOR REFERRING YOU?_____

MEDICAL HISTORY

PHYSICIAN'S NAME & PHONE #_____
DATE OF LAST MEDICAL EXAM_____
DRUG ALLERGIES_____
LIST MEDICATIONS NOW TAKING_____

HAVE YOU EVER HAD THE FOLLOWING: (CHECK ALL THAT APPLY)

____HIGH/LOW BLOOD PRESSURE	____PSYCHIATRIC CARE	____ASTHMA
____ MITRAL VALVE PROLAPSE	____CHEMICAL DEPENDENCY	____SWOLLEN GLANDS
____ HIP/ KNEE/VALVE ETC. REPLACEMENT	____EPILEPSY	____VENEREAL DISEASE
____ CIRCULATORY PROBLEMS	____HEADACHES	____RHEUMATIC FEVER
____HEART MURMUR	____ARTHRITIS	____ULCER
____STROKE	____HEPATITIS, JAUNDICE	____BLOOD DISEASE
____DIABETES	____LIVER DISEASE	____HEMOPHILIA
	____RESPIRATORY DISEASE	____AIDS OR OTHER IMMUNOSUPPRESSIVE DISORDER
	____SINUS PROBLEM	
	____CANCER	
	____RADIATION TREATMENT	____SPECIAL DIET

DENTAL HISTORY

HOW LONG HAS IT BEEN SINCE YOUR LAST EXAM & CLEANING?_____
WAS ALL TREATMENT COMPLETED AT THAT TIME?_____
WHAT IS YOUR FIRST VISIT TO OUR OFFICE FOR?_____

ARE YOU SATISFIED WITH THE APPEARANCE OF YOU TEETH?_____
IF NOT, PLEASE EXPLAIN YOUR CONCERNS._____

HAVE YOU EVER HAD ORTHODONTIC TREATMENT? (BRACES)_____
HAVE YOU EVER HAD PERIODONTIC TREATMENT? (GUMS)_____
DO YOU FLOSS REGULARLY?_____

PERSON RESPONSIBLE FOR ACCOUNT

NAME & ADDRESS_____
RELATIONSHIP TO PATIENT_____**COVERED BY INSURANCE?**_____

SIGNATURE_____ **DATE**_____