NEW PATIENT INFORMATION (CONFIDENTIAL)

Date ___________________

Full Name _____________________________________ Name you like to be called ________________

Mailing Address ____

City ____ State __________ Zip _____________________

Telephone (Home) _________________________ (Email Address) ___________________________

(Work) _________________________ (Cell) ____________________________________

Length of time in this area _____________________

Occupation ___________________________________

Hobbies or recreational activities ____

Children (ages)	**Marital Status**	**Do you live alone?**	**Date of Birth:**
__________ , ____	Married ________	Yes _____	___________________
__________ , ____	Unmarried _____	No _______	
__________ , ____	Widowed ______		

Person most important to you:
Name _____________________________________
Telephone ________________________________
Relationship ______________________________
Occupation _______________________________

Who referred you to our office? _______________________________________

Principle Dental problems:

	Pain	Appearance	Function
Teeth	________	_________	________
Dentures	________	_________	________
Partial Dentures	________	_________	________
Decay	________	_________	________
Gums	________	_________	________
Abscesses	________	_________	________
Implant(s)	________	_________	________

Other: ____

Dentist:

Name __________________________________ Phone ________________________________

Address ____

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Are you under their care now? _______________ Within the last year? _____________

Year of last dental care _________________ Year of last dental x-rays _______________

Describe the treatment you are interested in? ____

____

____

Physician:

Name ____________________________________ Phone _____________________________

Address ____

Specialty ______________________________ Are you under their care now? _____________

Do you smoke? _________________________

Denture Patients Only

Are you wearing?
Complete upper ______ or partial upper ______
Complete lower ______ or partial lower ______

How long have you had your current dentures? ______ years ______ months

How many times have you had dentures made? _______________________

When were your teeth extracted? __________________________________

What are your complaints with your current dentures? ________________________________

____

____

Were you pleased with these dentures when you first got them? Yes ______ No ______
If not, describe difficulties ____

Have you been pleased with any dentures you have had? ______________________________

Are you able to eat everything you would like? Yes ______ No ______

What are you not able to eat? ____

Do you get food under the: Upper ______ Lower ______

Does speech cause you problems? Yes ______ No ______
If so, please describe: ____

After evaluating your appearance:

Do you show enough tooth while: Speaking ______ Smiling ______

Do you like the tooth size? Yes ______ No ______

Do you like the tooth color? Yes ______ No ______

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Health History

Have you ever had any of the following (please circle Yes or No and give year):

Heart problems	N Y	______	Diabetes	N Y	______
Rheumatic Fever	N Y	______	High Blood Pressure	N Y	______
Heart Murmur	N Y	______	Hypoglycemia	N Y	______
Valve problems	N Y	______	Hepatitis	N Y	______
Bypass surgery	N Y	______	Liver disease	N Y	______
Asthma	N Y	______	HIV	N Y	______

Allergies ____

Other (list) ____

List **all** medications being taken:	Dosage:	Reason for taking:
____________________________	____________________	______________________
____________________________	____________________	______________________
____________________________	____________________	______________________
____________________________	____________________	______________________
____________________________	____________________	______________________
____________________________	____________________	______________________
____________________________	____________________	______________________
____________________________	____________________	______________________
____________________________	____________________	______________________
____________________________	____________________	______________________
____________________________	____________________	______________________

Do you have a ringing or buzzing in	right ear ____ left ear ____
Do you have any pain or tired feeling in the ear area?	Yes ____ No ____
Do you have headaches?	Yes ____ No ____
Do you have tension or pain at the base of the skull or neck?	Yes ____ No ____
Have you had any blows or injuries to the head, neck or mouth region?	Yes ____ No ____

Allergies (please list all): ____
____
____

Surgeries (please list all): ____
____
____

NEW PATIENT INFORMATION (CONFIDENTIAL)

Have you taken Fosamax? Y ____ N ____ If yes, when __________ If yes, IV ____ or pills ____
Boniva? Y ____ N ____ If yes, when __________ If yes, IV ____ or pills ____
Actonel? Y ____ N ____ If yes, when __________ If yes, IV ____ or pills ____
Other similar? Y ____ N ____ If yes, when __________ If yes, IV ____ or pills ____

Dental Insurance

Employer insurance provided by, if applicable: ____

Carrier Name: ____

Carrier's Address: ____

Carrier's Telephone #: _____________________

Policy or Group #: ________________________Group name: ______________________________

Subscriber SSN: _________________________ Subscriber DOB: __________________________

Patient's SSN: ____________________________

I consent to having any radiographs and/or photographs taken that are deemed necessary for treatment planning and/or treatment completion.

____

Signature (Parent if Minor) Date

Thank You For Completing This Form.