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 _____

NEW PATIENT INFORMATION (CONFIDENTIAL)

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.