

New Patient Form



Patient's Name: (Last) _____ (First) _____

Phone: (H) _____ (W) _____ (C) _____

Email: _____ Emergency Contact: _____ Phone: _____

Address: _____ (City) _____ (Postal Code) _____

Date of Birth: (DD / MM / YYYY) _____ Age: _____ Weight: _____ Gender: _____

CareCard: (#) _____ Medical Doctor: _____ Phone: _____

Your dentist is: _____ Phone: _____

Who referred you to our office: _____

DENTAL INSURANCE

Primary Insurance Carrier:	Policy #	ID #
Plan Holder's Name:	Dependant #	Policy Holder's DOB:
Second Dental Insurance Carrier:	Policy #	ID #
Plan Holder's Name:	Dependant #	Policy Holder's DOB:

DO YOU HAVE	YES	NO	NOT SURE	COMMENTS
Any history of major surgery?				Specify:
Any Anesthetic problems relating to any surgery?				If yes, explain:
Any heart problems or heart murmur?				Specify:
Have you ever tested positive for HIV?				<input type="checkbox"/> Treated <input type="checkbox"/> Not treated
Have you ever tested positive for Hepatitis A, B, C?				
Diabetes?				<input type="checkbox"/> Insulin <input type="checkbox"/> Diabetic pills <input type="checkbox"/> Diet controlled
TMJ (jaw) problems?				If yes, explain:
Do you take blood thinners? (Aspirin or Coumadin/Warfin etc)				Why?:
Do you take medication for Osteoporosis (e.g. Fosomax, etc)				
Any Stomach or intestinal disorders?				
ANY DRUG ALLERGIES				Please list:
ANY food or environment allergies				Please list:
Are you a smoker? (e.g. cigarettes, cigars, pipe, vape)				Specify:
Do you use marijuana / cannabis products?				Form taken: How often:
Are you now taking ANY medication?				
Women: Are you pregnant or is there a possibility you might be?				
Women: Are you taking birth control pills?				
Do you have any medical/dental condition or drug use you wish to discuss in private?				

DO YOU HAVE	YES	NO	DO YOU HAVE	YES	NO	DO YOU HAVE	YES	NO
Asthma			Shortness of Breath			Tuberculosis		
Rheumatic Fever			Glaucoma			Cancer		
Convulsive Seizures			Bleeding Problems			High Blood Pressure		

Patient Health Questionnaire completed by: *Patient* *Family member* *Health care provider* | Other: _____

Print Name(s): _____ Signature _____ Date (DD / MM / YYYY): _____

