Paul A. Smith D.M.D.

New Patient Form

We would like to welcome you to our office!

About You:

Today's Date: _____/_____/_____

Name: _____

I prefer to be called: _____ □ Male □ Female

Birthdate: ____/____/____ Age: ____ SS#: _____

Home Address: _____

_____

□ Single □ Married □ Partnered □ Divorced □ Widowed

Hm #: (____)_____ Cell: (____)_____

Wk #: (____)_____ Ext: ____ DL #: _____

Employer: _____

Employer's Address: _____

_____

How long there? _____ Occupation: _____

Where / When are the best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____

Person Responsible for Account: _____

Spouse Information:

His / Her Name: _____

Employer: _____

Wk #: (____)_____ Ext: ____ SS #: _____

Birthdate: ____/____/_____ DL #: _____

Relative or Friend not living with you.

Name: _____ Relation: _____

Hm #: (____)_____ Wk #: (____)_____

Insurance Information:

Primary Insurance

Dental Coverage? □ Yes □ No

Insurance Co. Name: _____

Insurance Address: _____

_____

Insurance Phone: (____)_____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's SS #: _____

Insured's Employer: _____

Employer's Address: _____

_____

Secondary Insurance

Dental Coverage? □ Yes □ No

Insurance Co. Name: _____

Insurance Address: _____

_____

Insurance Phone: (____)_____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's SS #: _____

Insured's Employer: _____

Employer's Address: _____

_____

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

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or exam rendered, to my insurance company.

_____

Signature Date:

Medical History:

Do you have a personal physician? □ Yes □ No

Physician's Name: _____

Phone #: _____ Date of Last Visit: ___/___/_____

Your Current physical health is: □ Good □ Fair □ Poor

Are you under the care of a physician? □ Yes □ No

Please explain: _____

Do you smoke or use tobacco in any other form? □ Yes □ No

Have you had any metal rods, pins, or implants? □ Yes □ No

Are you taking any prescription / OTC drugs? □ Yes □ No

Please list each one: _____

Have you ever taken any diet pills such as Phen-Fen? □ Yes □ No

If so, when? _____

For Women: Are you taking birth control pills? □ Yes □ No

Are you pregnant? □ Yes □ No Week # _____

Are you nursing? □ Yes □ No

Have you ever experienced the following medical problems?

Y	N	Abnormal Bleeding / Hemophilia	Y	N	Herpes / Fever Blisters
Y	N	AIDS	Y	N	High Blood Pres.
Y	N	Alcohol / Drug Abuse	Y	N	HIV +
Y	N	Anemia	Y	N	Hospitalized
Y	N	Artificial Bones/Joints/Valves	Y	N	Kidney Problems
Y	N	Asthma	Y	N	Liver Disease
Y	N	Blood Transfusion	Y	N	Low Blood Pres.
Y	N	Cancer / Chemotherapy	Y	N	Lupus
Y	N	Colitis	Y	N	M.Valve Prolapse
Y	N	Congenital Heart Defect	Y	N	Pacemaker
Y	N	Diabetes	Y	N	Psychiatric Treat.
Y	N	Difficulty Breathing	Y	N	Radiation Treat.
Y	N	Emphysema	Y	N	Scarlet Fever
Y	N	Epilepsy	Y	N	Seizures
Y	N	Fainting Spells	Y	N	Shingles
Y	N	Frequent Headaches	Y	N	Sickle Cell
Y	N	Glaucoma	Y	N	Sinus Problems
Y	N	Hay Fever	Y	N	Stroke
Y	N	Heart Attack / Heart Surgery	Y	N	Thyroid Problems
Y	N	Heart Murmur	Y	N	Tuberculosis TB
Y	N	Hepatitis	Y	N	Ulcers
Y	N	Venereal Disease	Y	N	Osteoporosis

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

Y	N	Asprin	Y	N	Erythromycin	Y	N	Penicillin
Y	N	Codeine	Y	N	Jewelry/Metals	Y	N	Tetracycline
Y	N	Dental Anesthetics	Y	N	Latex	Y	N	Other

Please list any other allergies: _____

Dental History:

What brings you to the dentist today? _____

_____

Are you currently in pain? □ Yes □ No

Do you require antibiotics before treatment? □ Yes □ No

Your Current Dental health is: □ Good □ Fair □ Poor

Have you ever had a serious problem associated with previous dental work? □ Yes □ No

Do you floss daily □ Yes □ No Brush daily □ Yes □ No

Type of bristles on your toothbrush? □ Hard □ Medium □ Soft

Have you ever had periodontal disease? □ Yes □ No

Do your gums ever bleed? □ Yes □ No Ever Itch? □ Yes □ No

Have you ever had gum treatment? □ Yes □ No

Have you ever had any pain / tenderness in your jaw joint (TMJ / TMD)? □ Yes □ No

Are your teeth sensitive to heat, cold, or anything else? _____

Do you have loose teeth? _____

Do you still have wisdom teeth? _____

Would you like fresher breath? □ Yes □ No Whiter teeth? □ Yes □ No

Are you happy with the way your smile looks? □ Yes □ No

If not, what would you change? _____

_____

HIPPA Compliance: Our office is HIPPA compliant.

I affirm that the information I have given in correct to the best of my knowledge. It will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status, I authorize the dental staff to perform the necessary dental services that I may need.

_____

Signature Date

Medical History Update:

Has there been any change in your health status since their last visit?

□ Yes □ No If yes, please explain. _____

_____

Patient Sig. _____ Date: ___/___/_____

Dentist Sig. _____ Date: ___/___/_____

For Office Use Only:

I have verbally reviewed the medical / dental information above with the patient name herein.

_____

Signature of Dentist Date

Dentist's Comments: _____

_____

_____

_____