New Patient Paperwork

1. Please enter your information.

First Name: _____ Middle Initials: _____ Last Name: _____ Date of Birth: _____

Gender:
○ Female ○ Male

Marital Status:
○ Single ○ Married ○ Domestic Partner ○ Separated ○ Divorced ○ Widowed

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

Preferred contact method:
○ Mobile Phone ○ Home Phone ○ Work Phone ○ Email

2. How did you learn about our practice or whom may we thank for referring you?

_____

_____

_____

_____

3. Reason for today's visit (your primary concern):

_____

_____

_____

_____

4. Level of anxiousness about visiting the dentist:

1 = None / 5 = Uncomfortable / 10 = Hiding under the bed

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

If greater than 3, please share your feelings:

_____

5. What questions would you like to have answered at your appointment?

_____

_____

_____

_____

6. What would you like to see happen with treatment?

7. Is there anything else you would like us to know before your visit?:

8. Who is responsible for your account and payment? (if different from previous listing)

Address: | Apt. / Unit #: | Birthdate:

Phone: | Email:

9. Primary Dental Insurance

Insurance company: | Phone # | Subscriber's Social Security #

Address: | Group #: | ID#:

How much is your deductible? | How much have you used?

What is your annual maximum benefit? | Whose name is this insurance under?

Employer offering this insurance? | Phone: | Address:

10. Secondary Dental Insurance

Insurance company: | Phone # | Subscriber's Social Security #

Address: | Group #: | ID#:

How much is your deductible? | How much have you used?

What is your annual maximum benefit? | Whose name is this insurance under?

Employer offering this insurance? _____ Phone: _____ Address: _____

11. Reason for today's visit:

_____

_____

_____

_____

12. Check if you have any problem with the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Sensitivity to any of the following: cold, hot, sweets
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Food collection between certain teeth
- ☐ Sensitivity when biting
- ☐ Sores or growth in your mouth
- ☐ Grinding teeth

13. When was your last dental visit? _____ Who was your previous dental provider? _____

How often do you brush? _____ How often do you floss? _____

14. Your physician: _____ Date of last visit: _____

15. Have you had any serious illnesses or operations? If yes, please describe.

_____

_____

_____

_____

16. Women

Are you pregnant? ○ Yes ○ No

Are you nursing? ○ Yes ○ No

Are you taking birth control? ○ Yes ○ No

17. Check if you have or have had any of the following:

- ☐ Anemia
- ☐ Arthritis, rheumatism
- ☐ Artificial heart valves
- ☐ Artificial joints, pins, etc.
- ☐ Asthma
- ☐ Bleeding abnormally
- ☐ Blood disease
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Chemotherapy
- ☐ Circulatory problems
- ☐ Congenital heart lesions
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart murmur
- ☐ Heart problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ HIV AIDS
- ☐ Jaw pain
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Mitral valve prolapse
- ☐ Pacemaker
- ☐ Radiation treatment
- ☐ Respiratory disease
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Sexually transmitted disease
- ☐ Stroke
- ☐ Swelling of feet or ankles
- ☐ Thyroid problems
- ☐ Tobacco use
- ☐ Tonsillitis
- ☐ q Tuberculosis
- ☐ Ulcer

18. List medications you are currently taking and the correlating diagnosis:

	Medication	Diagnosis
1		
2		
3		
4		

19. Please list any allergies you may have:

	Allergy
1	
2	
3	
4	

20. Airway

	Yes	No	Explain
While Awake: Mouth breathing preferred to nose breathing			
While Asleep: Mouth breathing preferred to nose breathing			

21. Sleeping pattern

	Yes	No	Explain
Move around a lot			
Usually takes less than 10 minutes to fall asleep			
Snoring			
Obstructive Sleep Apnea			

22. Pain / Symptoms

	Yes	No	Explain
Tooth pain/sensitivity			
Jaw joint pain			
Popping/clicking in jaw joint(s)			
Jaw muscle stiffness			
Head/Neck muscles stiffness			
Neck pain			
Headaches			

23. Indicate any history of (check all that apply); If checked "Yes", please explain.

	Yes	No	Explain
Thumb/finger sucking			
Injury to face or teeth			
Tongue and/or swallowing problems			
Speech problems			
Tonsils removed			
Crowns/Bridges			
Fillings			
Root canals			
Grinding and/or clenching of teeth			
History of wearing a mouthguard at night			
History of Periodontal disease			