# NEW PATIENT INFORMATION

PATIENT NAME: FIRST_____ MI_____ LAST_____

DOB_____ AGE_____ GENDER M or F SSN_____

ADDRESS_____ CITY_____ STATE _____ ZIP_____

HOME PHONE _____ WORK PHONE _____ CELL PHONE_____

EMPLOYER_____ OCCUPATION_____

PLEASE CIRCLE ONE: SINGLE MARRIED OTHER EMAIL_____

EMERGENCY CONTACT_____ PHONE_____ RELATION_____

NAME OF PERSON COMPLETING THIS FORM (IF DIFFERENT FROM PATIENT)_____

RELATION TO PATIENT_____

HOW DID YOU HEAR ABOUT OUR OFFICE? FRIEND/FAMILY/COWORKER INSURANCE WEBSITE SOCIAL MEDIA

# INSURANCE POLICY HOLDER INFORMATION

INSURED'S NAME: FIRST_____ MI_____ LAST_____

INSURED'S DOB_____ INSURED'S SSN_____ INSURED'S RELATION TO PATIENT_____

INSURANCE COMPANY_____ INSURANCE PHONE_____

INSURANCE GROUP#_____ INSURED'S EMPLOYER_____

# DENTAL HEALTH INFORMATION

| | YES | NO |
|---|---|---|
| DOES DENTAL TREATMENT MAKE YOU NERVOUS? | □ | □ |
| DO YOU HAVE ANY SENSITIVITY TO HOT, COLD, OR SWEETS? | □ | □ |
| DO YOUR GUMS BLEED? | □ | □ |
| DO YOU HAVE BAD BREATH? | □ | □ |
| DO YOU HAVE SORENESS IN JAW JOINTS? | □ | □ |
| DO YOU GRIND YOUR TEETH? | □ | □ |
| DO YOU SNORE? | □ | □ |
| DO YOU SMOKE, VAPE, OR USE TOBACCO OF ANY KIND? | □ | □ |
| IF YES, HOW MUCH? _____ | | |
| DO YOU USE MEDICAL MARIJUANA? | □ | □ |
| ARE YOU INTERESTED IN WHITENING YOUR TEETH? | □ | □ |
| ARE YOU INTERESTED IN BRACES? | □ | □ |
| ARE YOU INTERESTED IN REPLACING BLACK FILLINGS WITH TOOTH COLORED? | □ | □ |
| ARE YOU INTERESTED IN REPLACING MISSING TEETH? | □ | □ |

DATE OF LAST DENTAL CLEANING? _____
WAS IT A DEEP CLEANING/DID IT REQUIRE YOU TO GET NUMB? Y or N

HOW OFTEN DO YOU BRUSH? _____

DO YOU FLOSS? Y or N HOW OFTEN? _____

DO YOU WATERPIK? Y or N HOW OFTEN? _____

WHAT IS THE MOST IMPORTANT THING TO YOU ABOUT YOUR DENTAL VISIT TODAY? _____

_____

WHY DID YOU LEAVE YOUR PREVIOUS DENTIST? _____

_____

# GENERAL HEALTH INFORMATION

DO YOU HAVE A PRIMARY CARE PHYSICIAN? Y or N
PHYSICIAN'S NAME _____ PHYSICIAN'S PHONE_____

HAVE YOU HAD ANY SERIOUS ILLNESSES, OPERATIONS, OR HOSPITALIZATIONS IN THE PAST 5 YEARS? Y or N
IF YES, PLEASE EXPLAIN_____

DO YOU HAVE ANY ARTIFICIAL JOINTS, HEART VALVES, OR HEART STENTS? Y or N
IF YES, PLEASE EXPLAIN_____

HAVE YOU EVER BEEN TOLD YOU NEED TO TAKE AN ANTIBIOTIC BEFORE DENTAL TREATMENT? Y or N
IF YES, PLEASE EXPLAIN_____

| | YES | NO |
|---|---|---|
| **DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING**: | | |
| **CANCER** | □ | □ |
| TYPE_____ | | |
| CHEMOTHERAPY | □ | □ |
| RADIATION | □ | □ |
| **CARDIOVASCULAR** | | |
| ANGINA (CHEST PAIN) | □ | □ |
| ARTIFICIAL HEART VALVE | □ | □ |
| HEART ATTACK | □ | □ |
| HEART SURGERY | □ | □ |
| HYPERTENTION (HIGH BLOOD PRESSURE) | □ | □ |
| MITRAL VALVE PROLAPSE | □ | □ |
| PACEMAKER | □ | □ |
| PALPITATIONS | □ | □ |
| STROKE | □ | □ |
| **ENDOCRINOLOGY** | | |
| DIABETES | □ | □ |
| HEPATITIS A/B/C | □ | □ |
| KIDNEY DISEASE | □ | □ |
| LIVER DISEASE | □ | □ |
| HYPERTHYROIDISM | □ | □ |
| HYPOTHYROIDISM | □ | □ |
| **GASTROINTESTINAL** | | |
| ULCERS | □ | □ |
| GASTROINTESTINAL DISEASE | □ | □ |
| **HEMATOLOGIC/LYMPHATIC** | | |
| ANEMIA | □ | □ |
| BLOOD DISORDERS | □ | □ |
| BRUISE EASILY | □ | □ |
| EXCESSIVE BLEEDING | □ | □ |
| **MUSCULOSKELETAL** | | |
| ARTHRITIS | □ | □ |
| ARTIFICIAL JOINTS | □ | □ |
| **NEUROLOGICAL** | | |
| ANXIETY | □ | □ |
| DEPRESSION | □ | □ |
| DIZZINESS | □ | □ |
| DRUG/ALCOHOL ADDICTION | □ | □ |
| FAINTING | □ | □ |
| SEIZURES | □ | □ |

| | YES | NO |
|---|---|---|
| **RESPIRATORY** | | |
| ASTHMA | □ | □ |
| CORONAVIRUS | □ | □ |
| EMPHYSEMA | □ | □ |
| RESPIRATORY PROBLEMS | □ | □ |
| SINUS PROBLEMS | □ | □ |
| SLEEP APNEA | □ | □ |
| TUBERCULOSIS | □ | □ |
| **VIRAL INFECTIONS** | | |
| AIDS | □ | □ |
| HIV | □ | □ |
| HPV | □ | □ |
| **WOMEN ONLY** | | |
| CURRENTLY OR POSSIBILITY OF BEING PREGNANT | □ | □ |
| **MEDICAL ALLERGIES** | | |
| ANTIBIOTICS (PENICILLIN/AMOXICILLIN/CLINDAMYCIN) | □ | □ |
| OPIODS | □ | □ |
| LATEX | □ | □ |
| LOCAL ANESTHETICS | □ | □ |
| NSAIDS | □ | □ |
| OTHER_____ | | |

***PLEASE LIST ALL CURRENT MEDICATIONS OR PROVIDE A MEDICATION LIST:**

_____

_____

_____

**ANY ADDITIONAL COMMENTS:**

_____

_____

_____

I HEREBY AUTHORIZE DIRECT PAYMENT OF MY INSURANCE BENEFITS TO THOMAS DENTAL CARE. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS ASSOCIATED WITH MY DENTAL TREATMENT. I HEREBY AUTHORIZE THOMAS DENTAL CARE TO ADMINISTER SUCH MEDICATION AND PERFORM SUCH DIAGNOSTIC AND THERAPEUTIC PROCEDURES AS MAY BE NECESSARY FOR PROPER DENTAL CARE. I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH HISTORY AND REALIZE THAT INCOMPLETE INFORMATION MAY HAVE AN ADVERSE EFFECT ON MY TREATMENT. TO THE BEST OF MY KNOWLEDGE, THE INFORMATION ABOVE IS COMPLETE AND ACCURATE.

Patient Name: _____ Date: _____

Patient Signature: _____

Provider Signature: _____