New Patient Form

Name:	**DOB:**	**SS#:**	
Address:	**City:**	**State:**	**Zip:**
Home Phone:	**Cell Phone:**		
Email:	**Occupation:**		
Emergency Contact:	**Emergency Contact Phone:**		
Who may we thank for referring you:			

Insurance

Subscriber's Name:	**Insurance Company:**
Subscriber's SS#:	**Employer:**
Subscriber's DOB:	**Group #:**
Subscriber's Relationship to the Patient:	

Dental History

Do your gums bleed during brushing or flossing?	Yes	No
Are your teeth sensitive to hot, cold, or sweets?	Yes	No
Are any of your teeth painful?	Yes	No
Are there sores or lumps in or near your mouth?	Yes	No
Have you ever had orthodontic treatment (braces)?	Yes	No
Have you ever had a deep cleaning for gum disease?	Yes	No
Have you ever had a serious injury to the jaw?	Yes	No
Have you ever had problems with dental treatment?	Yes	No
Do you have clicking, popping or discomfort of the jaw?	Yes	No
Do you clinch or grind your teeth?	Yes	No
Do you have frequent headaches?	Yes	No

What is the reason for today's visit?
Date of last dental treatment:
What was done at this time?
Is there anything about your teeth that you would like to change?

Do you have or have you had any of the following conditions?

Cardiovascular Disease	Yes	No
High Blood Pressure	Yes	No
Heart Murmur	Yes	No
Mitral Valve Prolapse	Yes	No
Damaged Heart Valve	Yes	No
Artificial Heart Valve	Yes	No
Infective Endocarditis	Yes	No
Congenital Heart Defect	Yes	No
Pacemaker	Yes	No
Heart Attack	Yes	No
Stroke	Yes	No
Hemophilia	Yes	No
Abnormal Bleeding	Yes	No
Cancer	Yes	No

Diabetes Type I or Type II	Yes	No
Kidney Disease	Yes	No
Liver Disease	Yes	No
Osteoporosis	Yes	No
Migraine Headaches	Yes	No
Thyroid Problems	Yes	No
Frequent Sinus Infections	Yes	No
Acid Reflux	Yes	No
Bulimia	Yes	No
Colitis/Crohn's Disease	Yes	No
Gastrointestinal Disease	Yes	No
AIDS or HIV	Yes	No
Hepatitis	Yes	No
Tuberculosis	Yes	No

Joint Replacement

Have you ever had a total joint replacement?	Yes	No
If yes, have you ever had any complications?	Yes	No

Bisphosphonates/Bone Modifying Agents

Have you ever taken a Bisphosphonate medication including: Fosamax, Aredia, Actonel?	Yes	No
Have you ever taken denosumab (Xgeva, Prolia)?	Yes	No

Pregnancy/Nursing

Are you currently pregnant?	Yes	No
Are you currently nursing?	Yes	No

Social History

Do you smoke cigarettes or cigars?	Yes	No
Do you chew tobacco?	Yes	No
Do you use recreational drugs?	Yes	No

Please list any other health condition that you think we should know about:

List Current Medications

List Medication Allergies

Are you allergic to latex?	**Yes**	**No**

Signature of Patient or Guardian:_____ **Date:**_____