New Patient Adult 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

Do you have dental insurance?	**Yes**	**No**	**Please provide your insurance card to the front desk so that we can file claims on your behalf.**

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 clench 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		Diabetes Type I or Type II	Yes	No
High Blood Pressure	Yes	No		Kidney Disease	Yes	No
Heart Murmur	Yes	No		Liver Disease	Yes	No
Mitral Valve Prolapse	Yes	No		Osteoporosis	Yes	No
Damaged Heart Valve	Yes	No		Migraine Headaches	Yes	No
Artificial Heart Valve	Yes	No		Hypothyroidism	Yes	No
Infective Endocarditis	Yes	No		Hyperthyroidism	Yes	No
Congenital Heart Defect	Yes	No		Acid Reflux	Yes	No
Pacemaker	Yes	No		Bulimia	Yes	No
Heart Attack	Yes	No		Ulcerative Colitis/ Crohn's	Yes	No
Stroke	Yes	No		AIDS/HIV	Yes	No
Hemophilia	Yes	No		Hepatitis	Yes	No
Abnormal Bleeding	Yes	No		Tuberculosis	Yes	No
Cancer	Yes	No		Dementia	Yes	No

Please list other health conditions that you have:

Joint Replacement

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

Bisphosphonates/ Bone Modifying Agents

Have you ever taken a Bisphosphonate or other bone modifying medications such as Fosamax, Aredia, Actonel,Boniva, Xgeva, or 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

Sleep Apnea Screening Questions

Have you ever been diagnosed with Sleep Apnea?	Yes	No	
Do you snore?	Yes	No	
Do you wake up feeling like you haven't slept?	Yes	No	
Do you feel fatigued during the day?	Yes	No	
Have you been told that you stop breathing at night?	Yes	No	
Do you gasp for air or choke while sleeping?	Yes	No	
Do you use a CPAP machine?	Yes	No	

Allergies

Are you allergic to Latex?	Yes	No
Please List Medication Allergies:		

Please List Current Medications:

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