Best Impressions
Family Dentistry

New Patient Information

Basic Information

Name _____ Preferred Name _____
Last First Middle

Address _____

City _____ State _____ ZIP _____

○ Male ○ Female SS # _____ Date of Birth _____

Patient's Employer / School _____ Occupation _____

○ Work # _____ ○ Cell # _____ ○ Email _____

Check preferred method of contact (reminders, information regarding your appointment, etc.)

Spouse Information

Name _____ SS # _____ DOB _____

Employer _____ Work # _____

Complete this section if patient is a minor

Father's Name _____ SS # _____ DOB _____

Employer _____ Work # _____

Mother's Name _____ SS # _____ DOB _____

Employer _____ Work # _____

Insurance

Company Name _____

Policy # _____ Group # _____ Relationship to Insured (Select)

Insured's Name _____ Insured's SS # _____

Insured's DOB _____ Insured's Employer _____

New Patient Information

Contact / Reference

Name of Person to contact in case of emergency _____

Phone _____ Relationship _____

Who may we thank for referring you to our office? _____

Dental History

Name and Location of Previous Dentist _____

Date of Last Visit _____ Reason for Last Visit _____

Do your gums bleed while brushing or flossing? ○ Yes ○ No

Are your teeth sensitive to temperature and / or sweets? ○ Yes ○ No

Do you feel pain in any of your teeth? ○ Yes ○ No

Have you ever experienced any of the following problems in your jaw?

Clicking ○ Yes ○ No

Pain (joint, ear, side of face) ○ Yes ○ No

Difficulty in opening or closing ○ Yes ○ No

Difficulty in chewing ○ Yes ○ No

Do you have any sores or lumps in or near your mouth? ○ Yes ○ No

Do you clench or grind your teeth? ○ Yes ○ No

Have you ever had difficult extractions? ○ Yes ○ No

Have you had any prolonged bleeding following extractions? ○ Yes ○ No

Do you wear dentures or partials? ○ Yes ○ No

If yes, date of placement _____

Do you like your smile? ○ Yes ○ No

Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

Are you under medical treatment? ○ Yes ○ No Do you use tobacco? ○ Yes ○ No

Have you ever used Fen-Phen / Redux? ○ Yes ○ No

Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain ○ Yes ○ No

Are you taking any medication(s) including non-prescription medicine? If yes, what? ○ Yes ○ No

New Patient Information

Medical History (cont)

Are you allergic to any of the following?

Bleach	○ Yes ○ No	Sulfa Drugs	○ Yes ○ No	Latex Rubber	○ Yes ○ No
Codeine	○ Yes ○ No	Iodine	○ Yes ○ No	Other (please list)	○ Yes ○ No
Penicillin	○ Yes ○ No	Aspirin	○ Yes ○ No		
Other Antibiotics	○ Yes ○ No	Any Metals (e.g. nickel)	○ Yes ○ No		

Are you pregnant or think you may be pregnant? ○ Yes ○ No

Are you nursing? ○ Yes ○ No Are you taking oral contraceptives? ○ Yes ○ No

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

High Blood Pressure	○ Yes ○ No	Stroke	○ Yes ○ No	Hepatitis	○ Yes ○ No
Heart Attack	○ Yes ○ No	Tuberculosis	○ Yes ○ No	Sexually Transmitted Disease	○ Yes ○ No
Rheumatic Fever	○ Yes ○ No	Glaucoma	○ Yes ○ No	Stomach Trouble / Ulcers	○ Yes ○ No
Swollen Ankles	○ Yes ○ No	Liver Disease	○ Yes ○ No	Easily Winded	○ Yes ○ No
Fainting / Seizures	○ Yes ○ No	Respiratory Problems	○ Yes ○ No	Hay Fever / Allergies	○ Yes ○ No
Asthma	○ Yes ○ No	Heart Disease	○ Yes ○ No	Radiation Therapy	○ Yes ○ No
Low Blood Pressure	○ Yes ○ No	Cardiac Pacemaker	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No
Epilepsy / Convulsions	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Heart Trouble	○ Yes ○ No
Leukemia	○ Yes ○ No	Angina	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No
Diabetes	○ Yes ○ No	Anemia	○ Yes ○ No	Osteoporosis	○ Yes ○ No
Kidney Disease	○ Yes ○ No	Emphysema	○ Yes ○ No	Other (list)	○ Yes ○ No
AIDS or HIV Infection	○ Yes ○ No	Cancer	○ Yes ○ No		
Thyroid Problem	○ Yes ○ No	Arthritis	○ Yes ○ No		
Chest Pains	○ Yes ○ No	Joint Replacement or Implant	○ Yes ○ No		

Consent for Treatment & Payment Policy Agreement

I certify that I have completed this form fully and completely. The above information is accurate to the best of my knowledge and I understand that providing false information can be dangerous to my health. I grant authority to the Dentist and staff to perform the necessary exam, x-rays, and subsequent treatment needed to restore and maintain my dental health or the health of my dependent.

I have had the opportunity to read and have a copy of this office's Notice of Privacy Practices. I Authorize the Dentist to release any information including the diagnosis and the records of any treatment or exam rendered to me or my dependent during the period of such dental care to third party payors and / or other health practitioners as needed for my treatment and payment thereof.

I authorize and request my insurance company to pay benefits on my behalf directly to the dentist. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents including any collection costs including attorney fees and court costs.

Signature **Date**