NEW PATIENT GENERAL INFORMATION

To help us render the proper dental services to you, please answer the following questions.

PATIENT _____ _____ Cell Phone ( ) _____ Wk. Ph ( ) _____
FIRST NAME LAST NAME

Address _____ Hm. Phone ( ) _____

City/State/Zip _____ _____ _____ Email _____
CITY STATE ZIP

Birthdate ____ ____ ____ Driver's License # _____ Employer _____

Address _____

Sex ❑ M / ❑ F Social Security # _____ _____ _____ City/State/Zip _____ _____ _____
CITY STATE ZIP

What would you like us to call you? _____ Marital Status ❑ M / ❑ S / ❑ D / ❑ W / ❑ Sep

Whom should we call to confirm appointments? _____ Phone ( ) _____

Whom should we call in case of emergency? _____ Phone ( ) _____

Whom should we thank for referring you to us? _____ _____
FIRST NAME LAST NAME

Do you have any family members already in our practice? ❑ Yes ❑ No Who? _____

PERSON PAYING ACCOUNT _____ _____ Hm. Phone ( ) _____ Wk. Phone ( ) _____
FIRST NAME LAST NAME

Address _____ Occupation _____ Length of Employment _____

City/State/Zip _____ _____ _____ Employer _____
CITY STATE ZIP

Birthdate ____ ____ ____ Driver's License # _____ Address _____

Social Security # _____ _____ _____ City/State/Zip _____ _____ _____
CITY STATE ZIP

Place, time and number, during the day, to reach by phone _____

SPOUSE _____ _____ Hm. Phone ( ) _____ Wk. Phone ( ) _____
FIRST NAME LAST NAME

Address _____ Occupation _____ Length of Employment _____

City/State/Zip _____ _____ _____ Employer _____
CITY STATE ZIP

Birthdate ____ ____ ____ Driver's License # _____ Address _____

Social Security # _____ _____ _____ City/State/Zip _____ _____ _____

IF YOU HAVE DENTAL INSURANCE, PLEASE PROVIDE THE FOLLOWING

INS. COMPANY #1 _____

Address _____ Employee Name _____ _____
FIRST NAME LAST NAME

City/State/Zip _____ _____ _____ Employer Name _____
CITY STATE ZIP

Phone ( ) _____ Address _____

Birthdate ____ ____ ____ Social Security # ____ ____ ____ City/State/Zip _____ _____ _____
CITY STATE ZIP

Employee I.D. _____ Group # _____

INS. COMPANY #2 _____ Employee Name _____ _____
FIRST NAME LAST NAME

Address _____ Employer Name _____

City/State/Zip _____ _____ _____ Address _____
CITY STATE ZIP

Phone ( ) _____ City/State/Zip _____ _____ _____
CITY STATE ZIP

Birthdate ____ ____ ____ Social Security # ____ ____ ____ Group # _____

Our office policy is to request payment of fees at the time of service, or to collect your portion if you have insurance. For your convenience we accept cash, check, Visa, MasterCard, American Express, and Discover. With credit approval we can provide an extended payment plan. Account balances over 90 days past due will be submitted to an outside collection agency. A charge of $20.00 will be made for all returned checks. We reserve the right to charge $50.00 for all missed appointments, or for cancellations with less than 24 hours notice.

I acknowledge full responsibility for the payment of services.

I authorize Donna Peterson DDS to bill my insurance company(ies), and I authorize all insurance benefits to be paid directly to Donna Peterson DDS.

Signature of responsible party: _____ Date: _____ Relation to Patient: _____ Doctor's Initials: _____

NEW PATIENT HEALTH / DENTAL HISTORY

What is your main reason for being here? ❑ **Examination** / ❑ **Consultation** / ❑ **Emergency**

Do you have a specific dental problem? ❑ **Yes** / ❑ **No** _____

Do you think you have active decay? ❑ **Yes** / ❑ **No** / ❑ **Not Sure**

Do your gums ever bleed? ❑ **Yes** / ❑ **No** / ❑ **Sometimes**

Do you feel nervous about having dental treatment? ❑ **Yes** / ❑ **No**

Have you had a bad experience in a dental office? ❑ **Yes** / ❑ **No**

Do you brux or grind your teeth? ❑ **Yes** / ❑ **No** / ❑ **Sometimes**

Have you had orthodontic treatment (braces)? ❑ **Yes** / ❑ **No**

Do you have clicking, popping, or pain in your jaw (TMJ)? ❑ **Yes** / ❑ **No** / ❑ **Sometimes**

Do you Smoke? ❑ **Yes** / ❑ **No**

Do you consume alcoholic beverages? ❑ **Yes** / ❑ **No**

Are you taking any medication, drugs, or pills? ❑ **Yes** / ❑ **No** **Please list** _____

Have you been hospitalized in the last 5 years? ❑ **Yes** / ❑ **No** **Please explain** _____

Have you been told that you snore or stop breathing while asleep? ❑ **Yes** / ❑ **No**

HAVE YOU EVER HAD THE FOLLOWING:

Yes	No		Yes	No		Yes	No	
❑	❑	Heart Attack	❑	❑	Pacemaker	❑	❑	Mitral Valve Prolapse
❑	❑	Scarlet Fever	❑	❑	Hepatitis	❑	❑	Rheumatic Fever
❑	❑	Cancer	❑	❑	Chemotherapy	❑	❑	Kidney Problems
❑	❑	HIV / AIDS	❑	❑	Shingles	❑	❑	Radiation Treatment
❑	❑	Fever Blisters	❑	❑	Cold Sores	❑	❑	Artificial Joint
❑	❑	Stroke	❑	❑	Sinus Trouble	❑	❑	Artificial Valve
❑	❑	Diabetes	❑	❑	Tuberculosis	❑	❑	Under Psychiatric Care
❑	❑	Ulcers	❑	❑	Colitis	❑	❑	Drug/Alcohol Depend
❑	❑	Anemia	❑	❑	Asthma	❑	❑	Hemophilia / Bleeding
❑	❑	Arthritis	❑	❑	Empyhsema	❑	❑	Venereal Disease
❑	❑	Fainting	❑	❑	Glaucoma	❑	❑	Diffculty Breathing
❑	❑	Heart Surgery	❑	❑	Blood Transfusion	❑	❑	High / Low Blood Pressure
❑	❑	Heart Murmur	❑	❑	Bone loss drugs	❑	❑	Severe/Frequent Headaches
❑	❑	Endocarditis	❑	❑	Osteoporosis	❑	❑	Epilepsy/Seizures

ARE YOU ALLERGIC TO OR HAVE HAD DIFFICULTY WITH:

Yes	No				Yes	No	
❑	❑	Penicillin	❑	❑ Acetaminophen (Tylenol)	❑	❑	Latex
❑	❑	Aspirin			❑	❑	Metals
❑	❑	Sulfa	❑	❑ Codeine	❑	❑	Dental Anesthetic
❑	❑	Tetracycline	❑	❑ Ibuprofen (Advil)	❑	❑	Phen-Phen
❑	❑	Erythromycin			❑	❑	Other drugs

Any other condition not listed: _____

Prosthetics or Implants: _____

Type: _____

PLEASE CHECK ONE IN EACH SECTION:

❑ My mouth is very comfortable.
❑ My mouth is sometimes uncomfortable.

❑ I think the appearance of my smile is excellent.
❑ I am satisfied with the appearance of my smile.
❑ I am unconcerned about the appearance.
❑ I would like to change my smile.

❑ I will do whatever I must to keep my teeth.
❑ I want to keep my teeth but only within a certain budget of time and money.

❑ I have always done what was recommended to me.
❑ I have not done what was recommended to me.
❑ I have not had dentistry recommended to me.

❑ I think my present state of dental health is excellent.
❑ I think my present state of health is good.
❑ I think my present state of health is poor.

FOR WOMEN ONLY:

Are you Pregnant? ❑ **Yes** / ❑ **No**
Are you Nursing? ❑ **Yes** / ❑ **No**
Are you taking Birth Control Pills? ❑ **Yes** / ❑ **No**

Signature of responsible party: _____ Date: _____ Relation to Patient: _____ Doctor's Initials: _____