North Aiken Dental

New Patient Form

Today's Date: ____/____/____

Patient's Name: _____

Last First MI

What You Prefer To Be Called_____ Male___ Female___

Birthdate: ____/____/____ Age:_____ SSN#: _____

Mailing Address: _____

City State Zip Code\

Home Phone: (____)_____

Work Phone: (_____)_____

Cell Phone: (_____)_____

Email Address: _____

How Did You Hear About Us: _____

Employer: _____ How Long: _____

Employer's Address: _____

_____

City State Zip Code

Occupation: _____

Status: Minor__ Single__ Married__ Divorced__ Separated__ Widowed__

Spouse's Name: _____

Do You Have Any Children?: Yes (__) No (__) If yes, how many?_____

Accounting Info

Person Responsible for account

Name:_____

Relation: _____

Billing Address:_____

_____

City State Zip

SSN: _____

Driver's License:_____

Work Phone: _____

Insurance Info

Primary Insurance

Company Name: _____

Address:_____

_____

City State Zip

Phone: _____

Insured ID#: _____

Group#: _____

Insured's Name:_____

Relation: _____ Date Of Birth: ____/____/_____

Insured's Employer _____

Secondary Insurance

Company Name: _____

Address:_____

_____

City State Zip

Phone: _____

Insured ID#: _____

Group#: _____

Insured's Name:_____

Relation: _____ Date Of Birth: ____/____/_____

Insured's Employer _____

Emergency Contact

Whom Should We Contact: _____

Relation: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Who Is Your Medical Doctor: _____

Doctor's Phone Number: _____

Dental Information

Reason for today's visit: Exam(__) Emergency(__) Consultation(__)

Are you in pain: Yes(__) No(__) How long?:_____

Please Indicate any of the following problems:

(_)Discomfort, clicking, popping in jaw (_)Lost/broken filling(s) (_)Stained teeth (_)Broken/chipped tooth

(_)Blisters/Sores in or around mouth (_)Teeth grinding (_)Locking jaw (_)Sensitive tooth/teeth/gums

(_)Red, swollen or bleeding gums (_)Ringing In Ears (_)Bad Breath (_)Active decay/Cavity(ies)

(_)Other:_____

Do You Require pre-medication: (_)Yes (_)No (_)I Don't Know

Have You Ever Been Treated For Gum Disease?: (_)Yes (_)No

Previous Dentist: (Name & Address)_____

Last dental exam: ___/___/___ Last Dental X-Rays: ___/___/___ Last Dental Cleaning ___/___/___

Have you had previous problems with previous dental treatment? If so, explain below

_____

Times a day you brush? (__) Times a week you floss? (__) Type of tooth bristles (_)soft (_)med (_)hard

Rate your smile 1-10(10 being excellent) (__) Would you like whiter teeth? (_)Y (_)N

Have you had orthodontic treatment? (_)Y (_)N

Things you would change about your smile. _____

Medical History

What medications are you taking: (_)Nerve pills (_)Pain killers (including aspirin) (_)Muscle Relaxers (_)Stimulants (_)Blood Thinners (_)Tranquilizers (_)Insulin (_)Meds for Osteoporosis

(_)Vitamins/supplements: _____

(_)Others (please list): _____

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Murmur	Y N Heart surgery/pacemaker	Y N Shingles
Y N Lung Disease	Y N congenital heart defect	Y N Hepatitis
Y N Liver Problems	Y N artificial heart valves	Y N Glaucoma
Y N Blood Diseases	Y N mitral valve prolapse	Y N Arthritis/Gout
Y N Kidney Problems	Y N G.I. problems/ulcers	Y N Leukemia
Y N Scarlet Fever	Y N Emphysema/asthma	Y N Chest pains
Y N Tuberculosis TB	Y N Diabetes/Hypoglycemia	Y N Bruise easily
Y N HIV+/AIDS/ARC	Y N Psychiatric problems	Y N Allergies
Y N Rheumatic Fever	Y N Back/neck problems	Y N Nervousness
Y N Sinus Problems	Y N Respiratory problems	Y N Sleep Apnea
Y N Heart attack/stroke	Y N Heart disease/angina	
Y N Thyroid problems	Y N cancer/tumor(s)/growth(s)	
Y N Seizures/epilepsy	Y N Chemotherapy/radiation	
Y N Venereal Disease	Y N X-ray or Cobalt treatment	
Y N Cosmetic surgery	Y N Frequent thirst/urination	
Y N Dizziness/fainting	Y N Bleeding problems/anemia	
Y N Cold/fever blisters	Y N High/low blood pressure	
Y N Blood transfusion	Y N Artificial bones/joints/implants	
Y N Alcohol/drug abuse	Y N Severe/frequent headaches	
Y N Eating disorder	Y N Jaw Problems TMJ/TMD	

Please list any other surgeries or medical conditions that you have or ever had :_____

_____

Are you allergic to the following: (_)Latex (_)Penicillin/Amoxicillin (_)Tetracycline (_)Aspirin (_)Codeine (_)Dental Anesthetics

(_)Foods:_____ (_)Others: _____

Do you use tobacco: (_)No (_)Yes/How used:_____ How much _____ How long?_____

Please rate your general health from 1-10: _____ Do you wear contact lenses? (_)Y (_)N

For women: Are you taking birth control? (_)No (_)Yes/How far along:_____ Are you nursing: (_)N (_)Y

How many children have you had?:_____

__We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.

__Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date or services and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

__I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

__I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

_____(Initials) I acknowledge that I have received a copy of the Summary of Privacy Notice

Signature_____

(_)Adult Patient (_)Parent or Guardian (_)Spouse