



NEW PATIENT INFORMATION FORM

Name: _____

Email: _____

Phone Number: _____

Sex: _____ Birth Date: _____

Emergency Contact: _____ Phone Number: _____

Status:

Child Married Single

Widowed Divorced

Whom may we thank for your referral?

Google Yellow Pages

Newspaper Flyer

Website Other: _____

Have you been under the care of a medical doctor during the past two years?

Yes

No

Are you aware of having an allergic (or adverse) reaction to any medication or substance?

Yes

No

Indicate which of the following you have had, or presently have: (Optional)

<input type="checkbox"/> Heart (Surgery, Disease, Attack)	<input type="checkbox"/> Radiation Therapy	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Congenital Heart Disease	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Stomach Ulcers
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Nervous/Anxious	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Artificial Heart Valve
<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Mitral Valve Prolapse
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> A.I.D.S.	<input type="checkbox"/> Heart Pacemaker
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Cortisone Medicine	<input type="checkbox"/> Psychiatric/Psychological Care	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Swollen Ankles	<input type="checkbox"/> Kidney Trouble	<input type="checkbox"/> Yellow Jaundice
<input type="checkbox"/> Stroke	<input type="checkbox"/> Have you ever needed Premed prior to dental treatment?	<input type="checkbox"/> Tumors
<input type="checkbox"/> Are you taking blood thinners?	<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Chemotherapy
<input type="checkbox"/> Arthritis/Rheumatism	<input type="checkbox"/> Neurological Disorders	<input type="checkbox"/> Do you smoke?
<input type="checkbox"/> Allergies or Hives	<input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> Fainting or Dizzy Spells	<input type="checkbox"/> None of these options

Do you have, or have you had any medical conditions not listed?

Yes

No

FOR WOMEN (OPTIONAL)

Are you pregnant?	Are you nursing?	Are you taking birth control?
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No

What can we do to make YOU smile? Check all that apply.

- | | | |
|---|---|--|
| <input type="checkbox"/> Veneers/Crowns | <input type="checkbox"/> Correct Misaligned Teeth | <input type="checkbox"/> TMJ/Night Guard |
| <input type="checkbox"/> Sedation Dentistry | <input type="checkbox"/> Broken/Cracked Teeth | <input type="checkbox"/> Sports Guards |
| <input type="checkbox"/> Replace Metal Fillings | <input type="checkbox"/> Dental Implants | <input type="checkbox"/> Whitening |
| <input type="checkbox"/> Replace Missing Teeth | | |

<p>Are you apprehensive about dental treatment?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Do you have previous dental crowns?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Have you had problems with previous dental treatment?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does the saliva in your mouth seem too much?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Do you gag easily?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Have you had orthodontic (braces) treatment?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Do you wear dentures?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does food catch between your teeth?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Have you ever noticed a slow-healing sore in your mouth?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Do you have difficulty chewing your food?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Do you experience pain when you chew?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Do you avoid brushing any part of your mouth because of pain?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Do you have Temporomandibular Jaw Disorder (TMD)?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Are your teeth sensitive to cold?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Do you clench or grind your jaws frequently?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Are your teeth sensitive to heat?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Are you satisfied with the appearance of your teeth?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Are your teeth sensitive to sweets?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Do you experience headaches or migraines?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Are your teeth sensitive to sour?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Do you notice an unpleasant taste or odor in your mouth?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Do your gums bleed when you brush or floss?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Do you have sleep problems?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Do you have previous dental implants?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No

Treatment Consent

I, the undersigned, authorize **Smiles at Saddleridge** to perform any necessary dental services and oral surgery that I may need during my diagnosis and treatment with my informed consent. I certify that the medical and dental histories provided are accurate and complete to the best of my knowledge. I also understand that any and all dental services are my sole responsibility and that I should make myself aware of any fees associated with my dental care prior to treatment. I also acknowledge that there is no expressed, implied or guarantee of any procedure or dental treatment provided.

Signature