

## New Patient Information

### About You

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Email: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Person Responsible for Account if Other than Patient

Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Employer: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relation to you: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Spouse Information

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

### Insurance Information

Primary Insurance Company: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_\_ Policy Holder's ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance Company Phone: \_\_\_\_\_ Insurance Company Fax: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_\_ Policy Holder's ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance Company Phone: \_\_\_\_\_ Insurance Company Fax: \_\_\_\_\_

### PAYMENT IS DUE AT TIME OF SERVICE

I understand that I am responsible for payment of services rendered by Onsite Dental, and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the Onsite Dental to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

## DENTAL HISTORY

What concerns you most? \_\_\_\_\_

Are you having discomfort at this time? \_\_\_\_\_ What is the discomfort? \_\_\_\_\_

How long since you have been to a dentist? \_\_\_\_\_ Did you have X-Rays? \_\_\_\_\_ What else was done? \_\_\_\_\_

Are your teeth sensitive to: heat? \_\_\_\_\_ cold? \_\_\_\_\_ sweets? \_\_\_\_\_ sour? \_\_\_\_\_ pressure? \_\_\_\_\_

Have you ever had your teeth straightened? \_\_\_\_\_ If so, when? \_\_\_\_\_ Did you have traditional braces? \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_ How often do you use dental floss? \_\_\_\_\_

Do you have bleeding gums? \_\_\_\_\_ Have you ever had gum treatment? \_\_\_\_\_ When? \_\_\_\_\_

Do you grind or clench your teeth? \_\_\_\_\_ Do you hear popping or clicking noises when you chew? \_\_\_\_\_

Do you have any pain around either of your ears? \_\_\_\_\_ Any swelling or lumps in your mouth? \_\_\_\_\_

Do you have any fear of dental treatment? \_\_\_\_\_

How do you feel about the appearance of your teeth? \_\_\_\_\_

## MEDICAL HISTORY

Are you currently under a Physicians care? \_\_\_\_\_ Physician's Name \_\_\_\_\_

Physician's Address \_\_\_\_\_ Physician's Phone \_\_\_\_\_

Do you or have you experienced any of the following? (Please circle Y/N)

Y N Abnormal Bleeding	Y N Colitis	Y N Heart Murmur	Y N Liver Disease
Y N Alcohol Use	Y N Congenital Heart Defect	Y N Heart Surgery	Y N Lupus
Y N Anemia	Y N Diabetes	Y N Hemophilia	Y N Pacemaker
Y N Artificial Bones/Joints	Y N Emphysema	Y N Hepatitis	Y N Radiation Treatment
Y N Artificial Valves	Y N Fever Blisters	Y N Herpes	Y N Seizures
Y N Asthma	Y N Glaucoma	Y N High Blood Pressure	Y N Tobacco Use (Smoke/Chew)
Y N Cancer	Y N Headaches	Y N HIV+/AIDS	Y N Tuberculosis (TB)
Y N Chemotherapy	Y N Heart Attack	Y N Kidney Problems	Y N Venereal Disease

Please list any serious medical condition(s) that you have experienced. \_\_\_\_\_

Are you allergic to any of the following? (Please circle Y/N)

Y N Aspirin	Y N Erythromycin	Y N Sedatives
Y N Barbiturates	Y N Jewelry/Metals	Y N Sulfa Drugs
Y N Codeine	Y N Latex	Y N Tetracycline
Y N Dental Anesthetics	Y N Penicillin	Y N Other

Please list additional drugs/materials that cause allergic reactions: \_\_\_\_\_

Please list any and all medications you are currently taking: \_\_\_\_\_

**For Women:** Are you taking birth control pills? \_\_\_\_\_ Are you pregnant? \_\_\_\_\_ Week #: \_\_\_\_\_ Are you nursing? \_\_\_\_\_

## AUTHORIZATION

I affirm that the information I have given is correct to the best of my knowledge. All information herein will be held in the strictest confidence and it is my responsibility to inform Onsite Dental of any changes in my medical status. I authorize dental staff to perform the necessary dental services I may need, including x-rays, photographs, study models, or any aids deemed appropriate to make a thorough diagnosis of my dental needs.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.