# Adult New Patient Form

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## Today's Date:

## 1. PATIENT INFORMATION

Legal Name: _____
Preferred Name: _____
Legal Sex (please check one) ☐Female ☐ Male
Gender Identity (please specify as desired) _____
Birthdate _____ Age _____
SSN: _____
Marital Status:
☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Occupation:_____
Employer: _____
Employer Phone: _____

Home Address: _____
_____
City State Zip

Cell #: _____
Home #: _____
Work #: _____
Spouse's name: _____

Employer Address: _____

## 2. DENTAL INSURANCE

Who is responsible for this account? _____
Insurance Company: _____

Relationship to patient: _____
Group #: _____

Are you covered by additional insurance? ☐ Yes ☐ No (*if yes, please complete the following)*
Subscriber's name: _____
Subscriber's birthdate: _____
Subscriber's SSN: _____

Relationship to patient: _____
Insurance Company: _____
Group #: _____

## 3. EMERGENCY CONTACT INFORMATION

IN CASE OF EMERGENCY, CONTACT
Name: _____
Home #: _____
Cell #: _____

Relationship: _____
Work #: _____

## 4. DENTAL HISTORY

Reason for today's visit _____
_____
_____
How often do you brush your teeth? _____
How often do you floss your teeth? _____

Current Dentist's name: _____
Date of last dental visit: _____
Date of last dental x-rays: _____
Have you ever had any pain/tenderness in your jaw/joint (TMJ/TMD)? ☐ Yes ☐ No

How would you rate your dental health currently? ☐ good ☐ fair ☐ poor
Have there been any prior injuries to your teeth, face or mouth? ☐ Yes ☐ No

**Please check the box to indicate if you have had any of the following:**

☐ bad breath
☐ bleeding gums
☐ blisters on lips/mouth
☐ burning sensation on tongue
☐ chew on one side of the mouth
☐ cigarette, pipe or cigar smoking
☐ clicking or popping jaw
☐ dry mouth
☐ fingernail biting
☐ chew on foreign objects
☐ grinding teeth
☐ gums are swollen or tender
☐ jaw pain/tiredness
☐ lip/cheek biting
☐ loose teeth or broken fillings
☐ mouth breathing
☐ pain when brushing
☐ orthodontic treatment
☐ periodontal treatment
☐ sensitivity to cold
☐ sensitivity to hot
☐ sensitivity to sweets
☐ sensitivity when biting
☐ sores or growths in the mouth
☐ pain around ear
☐ food collection between the teeth

## 5. HEALTH HISTORY

Physician name: _____ Date of last visit: _____

Please describe your current physical health: ☐ Good ☐ Fair ☐ Poor

Have you ever had any of the following conditions?

- ☐ ADD/ADHD
- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis, Rheumatism
- ☐ Artificial heart valves
- ☐ Artificial joints
- ☐ Asthma
- ☐ Back problems
- ☐ Bleeding problems
- ☐ Blood disease
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Chemotherapy
- ☐ Circulatory problems
- ☐ Congenital heart defects
- ☐ Cortisone treatments
- ☐ Cough, persistent or bloody.
- ☐ Diabetes: type 1 or type 2
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting or Dizziness
- ☐ Gastrointestinal problems
- ☐ Headaches
- ☐ Heart murmur
- ☐ Heart problems
- ☐ Hepatitis Type _____
- ☐ Herpes
- ☐ High blood pressure
- ☐ Jaundice
- ☐ Jaw pain
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Low blood pressure
- ☐ Mitral valve prolapse
- ☐ Nervous problems
- ☐ Pacemaker.
- ☐ Psychiatric care
- ☐ Radiation treatment
- ☐ Respiratory disease
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Shortness of breath
- ☐ Sinus trouble
- ☐ Skin rash
- ☐ Special diet
- ☐ Stroke
- ☐ Swollen feet and/or ankles
- ☐ Swollen neck glands
- ☐ Surgery
- ☐ Thyroid problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor or growth on head or neck
- ☐ Ulcer
- ☐ Venereal disease
- ☐ Weight loss (unexplained)
- ☐ none of the above

If you checked any of these boxes or if you would like to discuss any other medical conditions you may have, please do so below:

_____
_____
_____

**List all drugs/medications** you are currently taking:

_____
_____

**List all allergies** (food, drug, latex, etc) currently have: _____
_____

## 6. SOCIAL HISTORY

Preferred language _____ Second Language _____

## 7. SIGNATURE

I understand that the information I have given is correct to the best of my knowledge and that it is my responsibility to inform the office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

_____ _____
Signature of Patient Date

**FOR OFFICE USE ONLY**

I verbally reviewed the medical/dental information above
With the parent/guardian and patient named herein

Initials: _____ Date _____

Doctor's Comments: _____
_____
_____