WELCOME

New Falls
DENTAL GROUP
Cosmetic, Implant & Familiy Dentistry

TODAYS DATE: ....

We would like to welcome you to our office. Our goal is to make everyone's visit pleasant and educational. We strive to teach good oral care that will enable you to have a beautiful smile that last a lifetime. Please visit us at www.newfallsdentalgroup.com

1. Patient Information

First Name: .... MI: ....

Last Name: ....

DOB: .... Age: .... SS#: ....

☐ Married ☐ Single ☐ Widowed ☐ Divorce ☐ Separated

Address: ....

....

Home #: .... Cell #: ....

Employer: .... Work #: ....

Occupation: ....

Email: ....

Referred by: ....

2. Responsible Party

First Name: .... MI: ....

Last Name: .... ☐ M ☐ F

DOB: .... Age: .... SS#: ....

Employer: .... Work #: ....

Occupation: ....

Employer's Address: ....

....

3. Primary Dental Insurance

Insurance Co. Name: ....

Insurance Co. Address: ....

Insurance Co. Phone: ....

Plan: .... Group: .... Policy: ....

Policy Owners Name: ....

Relationship to Patient: ....

Policy Owners DOB: .... SS#: ....

Policy Owners Employer: ....

Employees Address: ....

Orthodontic Coverage? ☐ Yes ☐ No

4. Secondary Dental Insurance

Insurance Co. Name: ....

Insurance Co. Address: ....

Insurance Co. Phone: ....

Plan: .... Group: .... Policy: ....

Policy Owners Name: ....

Relationship to Patient: ....

Policy Owners DOB: .... SS#: ....

Policy Owners Employer: ....

Employees Address: ....

Orthodontic Coverage? ☐ Yes ☐ No

5. Dental History

Purpose of todays visit: ....

Previous dentist: ....

When was your last visit: ....

What was done: ....

Last Cleaning: ....

How often do you brush: .... Gums bleed? ☐ Yes ☐ No

Any ☐ Sensitive teeth ☐ Loose teeth ☐ Broken Fillings
☐ Jaw pain ☐ Injuries to teeth

Explain: ....

Unpleasant Dental Experience? ☐ Yes ☐ No

Explain: ....

Have you ever had ☐ Orthodontics ☐ Gum Treatment
☐ Root Canal ☐ Oral Surgery ☐ Crowns Veneers ☐ Implants

Are you happy with the appearance of your teeth?
☐ Yes ☐ No ☐ Color ☐ Position ☐ Smile

Have you ever had tooth whitening? ☐ Yes ☐ No
☐ In Office ☐ Overnight ☐ Drug Store

Are you interested in replacing any missing teeth? ☐ Yes ☐ No

Which method: ☐ With Dentures ☐ Bridges ☐ Implants

Do you have any questions for the doctor? ☐ Yes ☐ No

I authorize the doctor to perform all recommended treatment agreed upon by me and to use the appropriate medication and therapy for such treatment in connection with ....
(NAME OF PATIENT)
I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and give consent to the doctor to use and employ such assistant as deemed fit to provide recommended treatment.

6. Medical History

Physicians Name: ....

Office Address: ....

Telephone: ....

Are you currently under the care of a physician? ☐ Yes ☐ No

Explain: ....

Has there been a recent change to your health? ☐ Yes ☐ No

Explain: ....

Are you currently taken any prescription, over the counter of recreational drugs? ☐ Yes ☐ No

Explain: ....

Have you been hospitalized or had a serious illness within the past five years? ☐ Yes ☐ No

Explain: ....

Please mark any allergies/adverse reactions:

Y N Penicillin
Y N Tetracycline
Y N Erythromycin
Y N Sulfa
Y N Local Anesthetics
Y N Codeine
Y N NSAID (Advil/Motrin)
Y N Aspirin
Y N Valium
Y N Barbiturates
Y N Latex
Y N Iodine
Y N Household Bleach
Other

Do you?

☐ Smoke Packs Per Day? .... How Long? ....
☐ Chew Tobacco
☐ Drink Per Week? .... Per Month? ....
☐ Wear Contact Lenses
☐ Take Diet Pills
☐ Take Herbal Supplements

Check if you have or ever had:

Y N Artificial Limb/joint/hip
Y N High/low Blood Pressure
Y N Organ Transplant
Y N Sinus Problems
Y N Migraines
Y N Frequent Headaches
Y N Claustrophobia
Y N Artificial Heart Valve
Y N Prolonged Bleeding
Y N Ulcers/colitis
Y N Hay Fever
Y N Head Injury
Y N Venereal Disease
Y N Mitral Valve Prolapse
Y N Anemia
Y N Acid Reflux
Y N Arthritis
Y N Epilepsy/seizures
Y N STD
Y N Rheumatic Fever
Y N Radiation Therapy
Y N Stomach Problems
Y N Glaucoma
Y N Dizziness/Fainting Spells
Y N Treated For AIDS, HIV, ARC
Y N Heart Murmur
Y N Thyroid Problems
Y N Used Phen Phen
Y N Chronic Diarrhea
Y N Stroke TIA
Y N Joint Surgery
Y N Cancer/chemotherapy
Y N Blood Disorder
Y N Increased Frequent Urination
Y N Bells Palsy
Y N Heart Disease
Y N Diabetes
Y N Asthma
Y N Night Sweats
Y N Psychiatric Or Emotional
Y N Recurrent Infections
Y N Angina
Y N Kidney Problems
Y N Bronchitis
Y N Addictions
Y N Pace Maker
Y N Liver Problems
Y N Emphysema
Y N TMJ Problems
Y N Shortness Of Breath
Y N Hepatitis: A or B or C
Y N Tuberculosis
Y N Unexplained Weight Loss
Y N Mouth Ulcers

7. Office Policy

We reserve the right to charge for any cancelled appointments if we do not receive 48 hours notice. All accounts sent to collections will be charged the account balance plus an additional 50% based on the account balance. Regardless of insurance, patients are fully responsible for any account balance. Patients are encouraged to ask all relevant dental & medical questions and thus fully understand the cost, time, limitations, and potential complications of any dental care they agree to receive. The dental profession can not be responsible for any treatment failures that are the result of patient neglect, injury or abuse. By my signature I hereby do certify that: I have read and understood the office policy. All information I have provided is accurate. I will update the office regarding any changes in this information. I will not hold any member of the dental staff responsible for actions resulting from any errors or omissions that I have made in the completion of this form. *Note: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.*

I certify that I have read and understand the above. I acknowledge that my questions, if any, have been answered to my satisfaction. I will not hold my dentist, or any other member of his or her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Our Legal Duty: We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect 04/14/2003 and will remain in effect until we replace it.

Accept Assignment: My signature authorizes the release of necessary information needed to process my claim, and to pay benefits to the provider of service.

8. For Completion By Dentist

Comments on patient interview concerning health history:

....

....

Significant findings from questionnaire or oral interview:

....

....

Dental Management considerations: ....

....

.... SIGNATURE OF PARENT OR GUARDIAN .... DATE

.... SIGNATURE OF DENTIST .... DATE