New Patient Form

Name* _____ Last Name* _____

Email* _____

Date of Birth (MM/DD/YYYY)* _____ Home Phone Number* _____

Work Phone Number _____ Cell Number _____

Street Address* _____

City _____ State / Province / Region _____

Postal / Zip Code _____ Country _____

Occupation* _____ Employer* _____

Spouse's Name _____ Spouse's Occupation _____

In case of emergency, please notify (please include phone #)*

_____

Citizenship* ☐ Canadian ☐ American ☐ Other

Do you have dental insurance? ☐ Yes ☐ No

Date of last physician exam (MM/DD/YYYY)* _____

What is your main dental concern?* _____

What was this exam for?* _____

Have you been hospitalized or had surgery in the last 10 years?* ☐ No ☐ Yes

Are you currently receiving care?* ☐ No ☐ Yes

List any previous surgeries: _____

Do you have or have you ever had any of the following?*

- ☐ Heart Condtions
- ☐ Diabetes
- ☐ Rheumatic Fever
- ☐ HIV Positive/AIDS Related Complex
- ☐ Emphysema or other Respiratory Illnesses
- ☐ Pacemaker
- ☐ Psychosis/Psychiatric Problems
- ☐ Slow Healing Mouth Sores
- ☐ Recurrent Illnesses
- ☐ Abnormal Bleeding from a Cut
- ☐ Liver Disease (including Jaundice)
- ☐ Unintentional Weight Loss/Gain
- ☐ None of the above
- ☐ Stroke
- ☐ Epilepsy
- ☐ Asthma
- ☐ Kidney Disease
- ☐ High Blood Pressure
- ☐ COPD
- ☐ Neurological Disorders
- ☐ Previous Biopsies
- ☐ Joint Replacement
- ☐ Latex Sensitivity
- ☐ Cancer
- ☐ Do you snore?
- ☐ Anemia
- ☐ Hepatitis, Any Form
- ☐ Abnormal Heart Condition
- ☐ Heart (Surgery, Disease, Attack)
- ☐ Artificial Heart Valve
- ☐ Been involved in a sleep study
- ☐ Sore/Enlarged Lymph Nodes
- ☐ Other infections
- ☐ Glaucoma
- ☐ Sickle Cell Disease
- ☐ Radiation/Chemotherapy
- ☐ Do you own a CPAP

Do you have a bleeding disorder, or a family history of bleeding disorders?* _____

Are you taking any of these medications?*

- ☐ Antibiotic before dental treatment?
- ☐ Antacids?
- ☐ Imitrex?
- ☐ Herbal supplements?
- ☐ None

Have you been treated with Bisphosphonate drugs (i.e. Fosamax)?* ☐ Yes ☐ No

Please list any medications you are currently taking including herbal remedies and the dosage:

Women: Are you pregnant?* ☐ Yes ☐ No

If no, are you planning a pregnancy in the near future?* ☐ Yes ☐ No

Are you a nursing mother?* ☐ Yes ☐ No

Are you taking birth control pills?* ☐ Yes ☐ No

Are you allergic or have you had a reaction to*

- ☐ Local anesthetics
- ☐ Penicillin
- ☐ Aspirin
- ☐ Latex
- ☐ Codeine, valium or other sedatives
- ☐ Other
- ☐ None

Are you a smoker?* ☐ Yes ☐ No

Do you consume grapefruit juice, grapefruits or grapefruit extract?* ☐ Yes ☐ No

Do you have or have you ever had any of the following?*

- ☐ Headaches
- ☐ Limited Opening
- ☐ Clenching
- ☐ Ringing in the Ears (tinnitus)
- ☐ Difficulty Chewing
- ☐ Neck Aches
- ☐ Insomnia/Frequent Waking
- ☐ Floss Shredding Between Teeth
- ☐ Food Packing Between Teeth
- ☐ Stroke
- ☐ Jaw Pain
- ☐ Congested Ears
- ☐ Loose Teeth
- ☐ Grinding
- ☐ Bell's Palsy
- ☐ Trigeminal Neuralgia
- ☐ Bleeding Gums
- ☐ Sensitive Teeth
- ☐ Anemia
- ☐ Jaw Popping or Clicking
- ☐ Dizziness
- ☐ Posture Problems
- ☐ Facial Pain
- ☐ Difficulty Swallowing
- ☐ Tingling Arms/Fingers
- ☐ Breath Concerns
- ☐ None of the above

Do you have any allergies, if so, please list them? ☐ No ☐ Yes _____

Is there anything else we should know about your health?*

Signature* _____ **Date (MM/DD/YYYY)*** _____