AESTHETIC DENTISTRY
CONFIDENTIAL PATIENT HEALTH RECORD
NEW PATIENT

PATIENT INFORMATION (PRINT ONLY PLEASE)

Date _____

Name _____ Nickname/preferred to be called _____ Birth Date _____

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Insurance Co(s) _____

Name of Insured _____ Employer _____

Insured Birthdate _____ Insured SS# _____

Emergency Contact _____ Relationship _____ Phone _____

What is your email address? _____ May we email you? _____

How did you hear about our office? _____

MEDICAL INFORMATION

Name of physician _____ Phone # _____

Are you taking any medication now, including regular dosages of aspirin? Yes __ No _____

If so, please list names & dosages _____

Are you allergic to: Penicillin ___ Codeine ___ Local Anesthetics ___ Latex ___ or any other substance? _____

Have you been under a physician's care during the last two years? _____

If so, what for? _____

Have you ever had major surgery? _____ If so, for what? _____

If female: Are taking hormones or birth control? _____ Are you pregnant or nursing? _____

Have you seen an ENT (ears, nose & throat doctor)? Yes ___ No ___ Name _____

Have you seen a chiropractor? Yes ___ No ___ Name _____

Have you seen a neurologist? Yes ___ No ___ Name _____

Have you had or do you have:

MI/Heart Attack	yes no	Prolonged Coughing	yes no	Neurological Disorders	yes no
Coronary Artery Disease	yes no	COPD	yes no	Head/Spine Injury	yes no
High Blood Pressure	yes no	Asthma	yes no	Trigeminal Neuralgia	yes no
Heart Valve Issues/MVP	yes no	Allergies	yes no	Tingling in Arms/Fingers	yes no
Require Antibiotics Prior to Dental Procedures	yes no	Cancer	yes no	TMJ	yes no
		Chemotherapy	yes no	Sleep Apnea	yes no
Congenital Heart Disease	yes no	Radiation Therapy	yes no	Ringing in Ears	yes no
Pacemaker	yes no	Dementia	yes no	Reflux	yes no
Abnormal Bleeding	yes no	Alzheimers	yes no	Thyroid Disease	yes no
AIDS/HIV	yes no	Anxiety	yes no	Diabetes	yes no
Hepatitis	yes no	CVA/Stroke/Mini Strokes	yes no	Kidney Disease/Dialysis	yes no
Anemia/Sickle Cell Anemia	yes no	Parkinsons	yes no	Liver Disease	yes no
Immune Deficiency	yes no	MS	yes no	Organ Transplant	yes no
Lupus	yes no	Seizures/Epilepsy	yes no		
Glaucoma	yes no	Psychiatric/Psychological	yes no		

Have you any disease, condition, or problem not previously listed? _____

Have you ever had any cosmetic procedure? ___ If yes, what? _____

OVER PLEASE

DENTAL HEALTH:

Our office is like few other dental offices. This will be the most important dental visit you will ever have. We place a high emphasis on helping you determine your present and future dental needs. There are some things we are going to be talking about at your first visit. These are issues you have probably not considered. Please check what best expresses how you feel about the following questions:

Why have you come to our office today?_____ Are you in pain? Yes No Explain:_____
Previous Dentist:_____ Phone: _____ Last visit date: _____
Have you ever been told that you require antibiotics before dental treatment? Yes No

Bad Breath	Yes No	Dry Mouth	Yes No	Orthodontic Treatment	Yes No
Bleeding Gums	Yes No	Grinding Teeth	Yes No	Pain When Brushing	Yes No
Blisters on lips or in mouth	Yes No	Swollen/Tender Gums	Yes No	Periodontal Treatments	Yes No
Broken Fillings	Yes No	Jaw Pain	Yes No	Sensitivity	Yes No
Clenching of Teeth	Yes No	Lip/Cheek Biting	Yes No	Snoring	Yes No
Clicking or popping of jaw	Yes No	Loose Teeth	Yes No	Sores in Mouth	Yes No

On a scale of 1 to 10, how would you rate your smile (10 being the best)? ____

Would you like whiter teeth? Yes No

Do you feel anxiety about dental treatment? Yes No

On a scale of 1 to 10, how would you rate your anxiety (10 being the most anxious? ____

I agree to pay the portion of my bill at the time of service that will not be paid by my insurance company, including any deductible and/or co-payment. I understand that the amount asked for is an estimate and that will will be billed the remainder of my balance if any insurance company does not pay promptly. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record. I hereby assign all dental/medical benefits to which I am entitled to Aesthetic Dentistry. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary to secure payment. I accept ultimate financial responsibility for accounts with Aesthetic Dentistry, whether paid by insurance or not. Accounts overdue by more than 30 days are subject to interest fees. Accounts overdue by 90 days as subject to late fees, collection charges, and/or attorney fees.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform my dental office of any changes in my medical status.

My signature below certifies that I have read and fully understand the above financial agreement.

Signature _____

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1) Date: _____

Please read the above and add new information (prescriptions, surgeries, insurance, allergies) here:

_____

_____

Signature:_____

2) Date: _____

Please read the above and add new information (prescriptions, surgeries, insurance, allergies) here:

_____

_____

Signature:_____

3) Date: _____

Please read the above and add new information (prescriptions, surgeries, insurance, allergies) here:

_____

_____

Signature:_____