onsite dental®
work. life. balance.

DATE: _____

New Patient Information

First Name	Middle Initial	Last Name	Date of Birth	Home Phone
Address	City	St	Zip Code	Drivers License
Social Security	Sex	M	F	Marital Status	Spouses Name

PATIENT INFORMATION

Occupation	Employer	Employer Address	
Employer City	Employer St	Employer Zip Code	Email Address
Alt. Email Address	Work Phone	Fax	Alt. Phone

EMPLOYMENT INFORMATION
SPOUSE INFORMATION

Spouse Occupation	Employer
Work Phone	Email Address

EMERGENCY INFORMATION

Emergency Contact Person				Relationship
Phone Number	Are you a Student?	Yes	No	If yes, Name of School

HOW DID YOU HEAR ABOUT ON-SITE DENTAL CARE?
(Please Check One)

☐ Email ☐ Saw Dental Practice ☐ Practice Open House ☐ Referral
If so, whom? _____
☐ Flyer ☐ Employee/Student ☐ Cafeteria Information Visit
☐ Poster ☐ Postcard ☐ Other

PERSON RESPONSIBLE FOR PAYMENT
(If other than patient)

First Name	Last Name	Social Security	Drivers License
Street Address	City	St	Zip Code

Occupation	Employer	Length of Employment

Employer Address	City	St	Zip Code	Employer Phone

DENTAL INSURANCE INFORMATION

	Primary Carrier	Secondary Carrier
Name of Employee		
Employee's Birthday		
Employee's Social Security		
Name of Employer		
Insurance Company		
Insurance Co. Address		
Coverage Effective Date		
Group or Policy Number		

Health History

It is important that we know your Medical and Dental History. These facts have a direct bearing on your dental health. We thank you for taking the time to fill this in as completely as possible.

I. CHECK THE APPROPRIATE ANSWER

	YES	NO	
1.	☐	☐	**Are you in pain now?** If yes, please describe:
2	☐	☐	Is your general health good?
3.	☐	☐	Has there been a change in your health in the last year?
4.	☐	☐	Have you ever been hospitalized or had a serious illness in the last three years? If yes, indicate why:
5.	☐	☐	Are you being treated by a physician now? If yes, please explain:
			Physician's name:
			Address:
			Phone number: Date of last medical exam
6.	☐	☐	Have you had any problems with prior dental treatment? If yes, please describe:

II. PLEASE LIST ALL SURGERIES AND HOSPITALIZATIONS.

_____Date: _____

_____Date: _____

_____Date: _____

III. Please list any current medications and/or drugs you are taking (please include any non-prescription vitamins & health supplements)	**IV. Please list any medications and/or drugs you have become sick from or have shown an allergic reaction to:**

V. HAVE YOU EVER EXPERIENCED:

	YES	NO			YES	NO	
1.	☐	☐	Chest pain?	2.	☐	☐	Angina?
3.	☐	☐	Swollen ankles?	4.	☐	☐	Ringing in ears?
5.	☐	☐	Shortness of breath?	6.	☐	☐	Headaches?

7.	☐	☐	Recent weight loss, fever, night sweats?	8.	☐	☐	Fainting spells?
9.	☐	☐	Persistent cough, coughing up blood?	10.	☐	☐	Blurred vision?
11.	☐	☐	Bleeding problem, bruising easily?	12.	☐	☐	Seizures, Epilepsy?
13.	☐	☐	Sinus problems?	14.	☐	☐	Excessive thirst?
15.	☐	☐	Difficulty Swallowing?	16.	☐	☐	Frequent urination?
17.	☐	☐	Diarrhea, constipation, blood in stools?	18.	☐	☐	Difficulty urinating, blood in urine?
19.	☐	☐	Frequent vomiting, nausea?	20.	☐	☐	Jaundice? (turned yellow)
21.	☐	☐	Dry mouth?	22.	☐	☐	Joint pain, stiffness?
23.	☐	☐	Anxiety, panic attacks?	24.	☐	☐	Dizziness?

VI. DO YOU HAVE OR HAVE YOU HAD:

	YES	NO			YES	NO	
1.	☐	☐	Heart Disease?	2.	☐	☐	Heart attack, heart defects?
3.	☐	☐	Heart murmurs, mitral valve prolapse?	4.	☐	☐	Rheumatic fever?
5.	☐	☐	Stroke, hardening of the arteries?	6.	☐	☐	High blood pressure?
7.	☐	☐	Hepatitis, other liver disease?	8.	☐	☐	Stomach problems, ulcers?
9.	☐	☐	Head injury?	10.	☐	☐	Cold sores?
11.	☐	☐	AIDS / HIV / Immune Disorder?	12.	☐	☐	Tumors, cancer?
13.	☐	☐	Arthritis, rheumatism?	14.	☐	☐	Eye diseases?
15.	☐	☐	Skin diseases?	16.	☐	☐	Anemia?
17.	☐	☐	VD (syphilis or gonorrhea)?	18.	☐	☐	Herpes?
19.	☐	☐	Kidney, bladder disease?	20.	☐	☐	Thyroid, adrenal disease?
21.	☐	☐	Allergies (food/drugs/meds/latex)?	22.	☐	☐	Diabetes?
23.	☐	☐	Family history of diabetes, tumors or heart problems?	24.	☐	☐	Asthma, TB, emphysema, or other lung disease?
25.	☐	☐	Organ Transplant?				

VII. HAVE YOU EVER BEEN TREATED WITH:

	YES	NO			YES	NO	
1.	☐	☐	Psychiatric care?	2.	☐	☐	Blood transfusions?
3.	☐	☐	Radiation treatments?	4.	☐	☐	Chemotherapy?
5.	☐	☐	Prosthetic heart valve?	6.	☐	☐	Pacemaker?
7.	☐	☐	Artificial joints?	8.	☐	☐	Artificial prosthesis (implant)?

VIII. ARE YOU TAKING OR HAVE YOU EVER TAKEN:

	YES	NO			YES	NO	
1.	☐	☐	Recreational drugs?	2.	☐	☐	Alcohol?
3.	☐	☐	Fen-Phen, Redux, Steroids, Cortizone	4.	☐	☐	Tobacco?

5 If you have quit any of the above, please indicate when? _____

IX. ALL PATIENTS:

	YES	NO			YES	NO	
1.	☐	☐	Do you wear corrective lenses?	2.	☐	☐	Do you wear contact lenses?

3. ☐ ☐ Do you have or have you had any other diseases or medical problems NOT listed on this form? If yes, please explain: _____

X. WOMEN ONLY:

	YES	NO			YES	NO	
1.	☐	☐	Are you or could you be pregnant?	2.	☐	☐	Are you anticipating becoming pregnant?
3.	☐	☐	Are you nursing?	4.	☐	☐	Are you taking birth control pills?

XI. DENTAL HISTORY:

1. What is the purpose of your visit today? _____
2. How long has it been since your last dental visit? _____ Full mouth X-ray? _____
3. Name and Address of former Dentist: _____

XII. CHECK THE APPROPRIATE ANSWER:

1. Do you experience sensitivity to:
   Hot? ☐ Cold? ☐ Sweets? ☐

	YES	NO			YES	NO	
2.	☐	☐	Have you ever had an injury to your face, neck or jaw? If yes, please explain: _____				
3.	☐	☐	Do you grind your teeth?	4.	☐	☐	Have you ever had "clicking" or "popping" in your ears when chew?
5.	☐	☐	Do your gums bleed?	6.	☐	☐	Have you had gum (periodontal) surgery?
7.	☐	☐	Have you had an unfavorable experience from local anesthetics?	8.	☐	☐	Have you had orthodontic appliances (braces)?
9.	☐	☐	Is there anything you would like to discuss in private with the Doctor? _____				

XIII. SECURITY

1. What is your Mother's Maiden Name? _____

To the best of my knowledge, I have answered every question completely and accurately.

I will inform my dentist of any change in my health and/or medication.

Patient signature: _____ Date: _____
(print) (sign)

CONSENT

I confirm as true the above health information. I hereby authorize the dentist to take x-rays, study models, photographs, or any aids deemed appropriate by the dentist in charge of my care to make a thorough diagnosis of my dental needs. I also authorize the dentist to perform any and all forms of treatment, medication and therapy that may be necessary for my dental health.

Signature: _____ Date: _____
(print) (sign)