

NEW PATIENT INFORMATION



Date _____

Patient's Name _____ Home Phone _____

Name of Spouse _____ Work Phone _____

If a Child, Parent's Name _____ Social Security No. _____

Street Address _____ Birth Date _____

City _____ Marital Status _____

State _____ Zip _____ Title: Mr. Miss Mrs. Ms. Dr.

Sex: M F (circle one)

Whom may we thank for referring you? _____

Employer's Name _____ Present Position _____

Employer's Address _____

Spouse employed by _____ Present Position _____

Employer's Address _____

Purpose of this appointment _____

In case of emergency, who should be notified? _____

Do you have insurance that may cover part of our professional services? _____

If using a charge card, give name and number of card. _____

DENTAL HISTORY

When/where was your last dental exam? _____

When was your last full mouth X-ray taken? _____ Where? _____

Have you ever had Novocaine or other local anesthetic? _____ Yes _____ No

Have you ever had Nitrous Oxide (laughing gas)? _____ Yes _____ No

Have you ever had prolonged bleeding following extractions? _____ Yes _____ No

Have you ever been premedicated with antibiotics for any procedure? _____ Yes _____ No

Please explain _____

Name and address of previous D.D.S. _____

Please complete reverse side.

