NEW VIEW DENTAL

Welcome to New View Dental – Tell Us About Yourself

Name: _____
Last First MI Title

Preferred Name: _____ ❑ Male ❑ Female

Address: _____ City _____ State _____ ZIP_____

SSN: _____ DOB: _____

Home Phone: _____ Work Phone: _____

Cell Phone:_____ E-mail Address: _____

Employer:_____ Occupation: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Domestic Partner

How did you hear about our office?_____

Do you prefer to be contacted for appointment confirmation via e-mail, phone, or text? **(Please Circle)**

In case of an emergency, whom may we contact?
Name: _____
Telephone: _____
Relationship: _____

■ Dental Insurance – Primary ■

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____

Subscriber SSN/ID: _____ Subscriber Employer: _____

Insurance Company Name: _____

Insurance Company Address:_____

Insurance Company Phone: _____ Group Number: _____

■ Dental Insurance – Secondary ■

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____

Subscriber SSN/ID: _____ Subscriber Employer: _____

Insurance Company Name: _____

Insurance Company Address:_____

Insurance Company Phone: _____ Group Number: _____

■ Assignment and Release ■

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to New View Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____

Relationship: _____ Date: _____

CONSENT: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient/Guardian Signature:_____

Medical History

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name:_____

Physician's Phone: _____

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Do you use tobacco in any form? ❑ Yes ❑ No

If yes, please specify which forms:_____

Are you taking or have you recently taken any prescription or over-the-counter medications? ❑ Yes ❑ No

If so, please list all- including vitamins, natural or herbal preparations and/or dietary supplements:

_____

_____

_____

Have you ever had any serious illness, operation or been hospitalized in the past 5 years? ❑ Yes ❑ No

If yes, what was the illness or problem:

_____

_____

Are you or have you ever been allergic to: (Please specify below)	Yes	No
Local anesthetics…….	❑	❑
Antibiotics	❑	❑
Sedatives ……	❑	❑
Aspirin……..	❑	❑
Ibuprofen ……	❑	❑
Tylenol……	❑	❑
Any metals ……	❑	❑
Latex……...	❑	❑
Codeine……...	❑	❑
Hydrocodone……...	❑	❑

Please list any other allergies you may have:

_____

_____

To the best of your knowledge, have you ever had or been diagnosed with:

Yes	No	Conditions	Yes	No	Conditions	Yes	No	Conditions
❑	❑	Tuberculosis	❑	❑	Glaucoma	❑	❑	Orthopedic Joint replacement
❑	❑	Abnormal Bleeding	❑	❑	HIV+ AIDS	❑	❑	Artificial Heart valve
❑	❑	Alcohol Abuse	❑	❑	Heart Attack	❑	❑	Previous Infective Endocarditis
❑	❑	Anemia	❑	❑	Heart Murmur	❑	❑	Damaged Valves In Transplanted Heart
❑	❑	Chest Pain	❑	❑	Heart Surgery	❑	❑	**Congenital Heart Disease (CHD):**
❑	❑	Arthritis	❑	❑	Hemophilia	❑	❑	Unrepaired, Cyanotic CHD
❑	❑	COPD	❑	❑	Hepatitis A	❑	❑	Repaired (Completely) In Last 6 Months
❑	❑	Asthma	❑	❑	Hepatitis B	❑	❑	Repaired CHD With Residual Defects
❑	❑	Acid Reflux	❑	❑	Hepatitis C			
❑	❑	Cancer	❑	❑	High Blood Pressure			
❑	❑	Chemotherapy	❑	❑	Low Blood Pressure			
❑	❑	Type 1 Diabetes	❑	❑	Heart Stents			
❑	❑	Type 2 Diabetes	❑	❑	Kidney Problems			
❑	❑	Drug Abuse	❑	❑	Liver Disease			
❑	❑	Emphysema	❑	❑	Mitral Valve Prolapse			
❑	❑	Epilepsy	❑	❑	Pacemaker			
❑	❑	Facial Surgery	❑	❑	Snoring/Sleep Apnea			
❑	❑	Fainting Spells	❑	❑	Sickle Cell Disease			
❑	❑	Fever Blisters	❑	❑	Sinus problems			
❑	❑	Frequent Headaches	❑	❑	Stroke			
❑	❑	Psychiatric Problems	❑	❑	Thyroid Problems			
❑	❑	Radiation Therapy	❑	❑	Rheumatic fever			

Yes	No	**If Female, Please Answer**
❑	❑	Are you pregnant?
		If so, # of weeks: _____
❑	❑	Taking Birth Control?
❑	❑	Nursing?

Has a physician recommended that you take antibiotics prior to your dental treatment? ❑ Yes ❑ No

Name and phone number of physician making recommendation: _____

Are you taking or scheduled to begin taking Bisphosphonate medications including:

Fosamax, Actonel, Atelvia, Boniva, Reclast, or Prolia? ……❑ Yes ❑ No

If yes, have you received:

*Past or current chemotherapy ……❑ Yes ❑ No

*The intravenous medications

Zometa, Aredia, or Bonefos ……..❑ Yes ❑ No

Do you use controlled substances (drugs)? ❑ Yes ❑ No

Do you have any disease, condition, or problem not listed above that you think I should know about?

_____

_____

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 and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/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. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature:_____

Date:_____

Dental History

How may we help you today? _____

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

Are you currently in pain? ❑ Yes ❑ No

Have you ever had a serious injury to your head or mouth? ❑ Yes ❑ No

Are your teeth sensitive to hot, cold, or sweets? ❑ Yes ❑ No **(If yes, please circle which ones)**

Have you ever had a deep cleaning? ❑ Yes ❑ No

Do your gums bleed? ❑ Yes ❑ No

Is your mouth dry? ❑ Yes ❑ No

Do you now or have you had any pain/discomfort in your jaw joint? (TMJ) ❑ Yes ❑ No

Is there anything you would like to change about your smile? ❑ Yes ❑ No

Are you happy with the color of your teeth? ❑ Yes ❑ No

How many times a day do you: Floss _____ Brush____

Have you ever had a serious/difficult problem with any previous dental work? ❑ Yes ❑ No

Have you ever had a poor dental experience? ❑ Yes ❑ No

When was your last dental cleaning? _____

Why did you leave your previous dentist? _____

How can we accommodate you better during your dental visit?_____

Here at New View Dental we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below you would like our friendly staff to discuss with you during your visit.

Implants	Sealants
Invisalign	Smile Makeover
Teeth Whitening	Crown and Bridge
Partials/Dentures	Night/Sport Guards