Advanta Dental Group New Patient Information

THIS INFORMATION IS NECESSARY FOR OUR FILES AND WILL BE CONSIDERED CONFIDENTIAL

PATIENT INFORMATION

PATIENTS NAME: _____ DATE: _____
LAST FIRST INITIAL
MALE FEMALE
AGE: _____
BIRTH DATE: _____

IF PATIENT IS A MINOR, GIVE PARENT OR GUARDIAN NAME: _____
RELATIONSHIP: _____

ADDRESS: _____
STREET CITY, STATE ZIP
DRIVER'S LICENSE: _____ SSN _____ PHONE: _____

EMPLOYED BY: _____ OCCUPATION: _____
BUSINESS ADDRESS: _____ BUS PHONE _____

SPOUSE'S NAME: _____
DRIVER'S LICENSE: _____ SSN _____ PHONE: _____

EMPLOYED BY: : _____ OCCUPATION: _____
BUSINESS ADDRESS: _____ BUS PHONE _____

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU: RELATIONSHIP: _____
_____

ADDRESS: _____
STREET CITY ZIP
PHONE: _____

NAME OF PHYSICIAN: _____ PHONE: _____
ADDRESS: _____
STREET CITY ZIP

FORMER DENTIST: _____ PHONE: _____
ADDRESS: _____
STREET CITY ZIP

WHOM MAY WE THANK FOR REFERRING YOU TO US?
NAME: _____ EMAIL: _____ PHONE: _____

Advanta Dental Group New Patient Information

HEALTH HISTORY

THESE QUESTIONS ARE FOR YOUR BENEFIT AND ASSURE THAT TREATMENT WILL TAKE INTO CONSIDERATION YOUR PAST AND PRESENT HEALTH STATUS. SOME QUESTIONS MAY SEEM UNRELATED TO YOUR DENTAL CONDITION, BUT THEY ARE ALL ASSOCIATED WITH PROPER ORAL HEALTH CARE. PLEASE ANSWER EACH QUESTION. CHECK YES OR NO WHERE APPLICABLE.

1. ARE YOU IN GOOD HEALTH?	☐ YES ☐ NO
2. DATE OF LAST PHYSICAL EXAMINATION: _____	
3. ARE YOU UNDER THE CARE OF A PHYSICIAN? IF SO, WHAT IS THE CONDITION YOU ARE BEING TREATED FOR? _____	☐ YES ☐ NO
4. HAVE YOU EVER HAD A SERIOUS ILLNESS OR OPERATION? IF SO, WHAT ILLNESS OR OPERATION? _____	☐ YES ☐ NO
5. HAVE YOU EVER BEEN HOSPITALIZED? IF SO, FOR WHAT REASON? _____	☐ YES ☐ NO
6. ARE YOU TAKING ANY DRUGS OR MEDICATIONS? IF SO, LIST THEM HERE ALONG WITH THE DOSAGE: DRUG NAME: _____ DOSAGE: _____ DRUG NAME: _____ DOSAGE: _____ DRUG NAME: _____ DOSAGE: _____ DRUG NAME: _____ DOSAGE: _____ DRUG NAME: _____ DOSAGE: _____	☐ YES ☐ NO

7. ARE YOU SENSITIVE OR ALLERGIC TO ANY OF THE FOLLOWING DRUGS? CHECK WHICH ONES APPLY:

☐ PENICILLIN ☐ TETRACYCLINE ☐ SULFA DRUGS ☐ ASPIRIN ☐ CODEINE

OTHER. PLEASE LIST: _____

8. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? PLEASE INDICATE ALL KNOWN CONDITIONS:

(continued below) ...

Advanta Dental Group New Patient Information

HEALTH HISTORY CONTINUED…..

○	ANEMIA	○	HEMOPHILIA	○	DRUG ADDICTION	○	TUMORS OR GROWTHS
○	HERPES	○	STROKE	○	EPILEPSY/SEIZURES	○	RHEUMATISM
○	ULCERS	○	KIDNEY DISEASE	○	ALLERGIES OR HIVES	○	HEART MURMUR
○	BRUISE EASILY	○	STOMACH ULCERS	○	CONGENITAL HEART LESION		
○	DIABETES	○	CORTISONE MEDICATIONS	○	ARTIFICIAL PROSTHESIS		
○	HEAD INJURY	○	PSYCHIATRIC TREATMENT	○	X-RAY OR COBALL TREATMENT		
○	ASTHMA	○	MENTAL DISORDER	○	RADIATION TREATMENT OF ANY KIND		
○	GLAUCOMA	○	EXCESSIVE BLEEDING	○	HEPATITIS OR JAUNDICE		
○	ARTHRITIS	○	ANGINA PECTORIS	○	VENEREAL DISEASE (SYPHILIS, GONORRHEA)		
○	LIVER DISEASE	○	HEART FAILURE	○	ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)		
○	THYROID DISEASE	○	RHEUMATIC FEVER	○	AIDS RELATED COMPLEX		
○	EMPHYSEMA	○	HIGH BLOOD PRESSURE	○	CHEMOTHERAPY (CANCER, LEUKEMIA)		
○	SCARLET FEVER	○	CEREBRAL PALSY	○	DIFFICULTY SWALLOWING		
○	HAY FEVER	○	PAIN IN JAW JOINTS	○	HEART AILMENTS OR ATTACKS		
○	CHICKEN POX	○	BLOOD TRANSFUSION	○	FAINTING SPELLS OR SEIZURES		
○	TONSILLITIS	○	SINUS TROUBLE	○	RESPIRATORY DISEASE		
○	COLD SORES	○	JOINT REPLACEMENT	○	SICKLE CELL DISEASE		
○	BLOOD DISEASE	○	NERVOUS DISORDERS	○	TUBERCULOSIS (TB)		
○	PHEN PHEN		OTHER: _____				

9. DO YOU WEAR A CARDIAC PACEMAKER, OR HAVE YOU HAD A HEART PROBLEM?	☐ YES ☐ NO

Advanta Dental Group New Patient Information

10. DO YOU HAVE ANY DISEASE, CONDITION, OR PROBLEM NOT LISTED THAT YOU THINK I SHOULD KNOW ABOUT? IF SO, PLEASE DESCRIBE: _____ _____	☐ YES ☐ NO
11. ARE YOU PREGNANT? IF SO, HOW MANY MONTHS? _____.	☐ YES ☐ NO
12. DO YOU HAVE ANY PROBLEMS ASSOCIATED WITH YOUR MENSTRUAL PERIOD? IF SO, PLEASE DESCRIBE. _____ _____	☐ YES ☐ NO
13. DO YOU TAKE BIRTH CONTROL PILLS?	☐ YES ☐ NO

DENTAL HISTORY	
1. HAVE YOU EVER HAD A LOCAL ANESTHETIC (NOVOCAINE, ETC..)	☐ YES ☐ NO
2. HAVE YOU EVER HAD ANY UNFAVORABLE REACTION FROM LOCAL ANESTHETIC?	☐ YES ☐ NO
3. HAVE YOU HAD ANY SERIOUS TROUBLE ASSOCIATED WITH PREVIOUS DENTAL TREATMENT? IF SO, EXPLAIN: _____ _____	☐ YES ☐ NO
4. HOW LONG SINCE YOUR LAST FULL MOUTH X-RAYS? _____	
5. HOW LONG SINCE YOUR LAST DENTAL TREATMENT? _____	
6. DOES DENTAL TREATMENT MAKE YOU NERVOUS? IF SO, CHECK TO WHICH DEGREE YOU ARE NERVOUS: SLIGHTLY MODERATELY EXTREMELY	☐ YES ☐ NO
7. DO YOU DESIRE A SEDATIVE FOR YOUR TREATMENT?	☐ YES ☐ NO
TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING ANSWERS ARE TRUE AND CORRECT. IF I EVER HAVE ANY CHANGE IN MY HEALTH OR IF MY MEDICATIONS CHANGE, I WILL WITHOUT FAIL, INFORM THE DOCTOR AT MY NEXT APPOINTMENT. DATE: _____ SIGNATURE: _____	

Advanta Dental Group New Patient Information

THIS HEALTH QUESTIONNAIRE MUST BE UPDATED EVERY YEAR

YEAR 2 CHANGES IN HEALTH: _____

_____

DATE: _____ SIGNATURE: _____

YEAR 3 CHANGES IN HEALTH: _____

_____

DATE: _____ SIGNATURE_____

For office use only

Reviewed by:

Year 1 _____

Year 2 _____

Year 3 ____

Year 1	Year 2	Year 3
date:	date:	date:
bp:	bp:	bp:
pulse:	pulse:	pulse:
temp:	temp:	temp:

FINANCIAL INFORMATION

DO YOU HAVE DENTAL INSURANCE?
☐ YES ☐ NO

NAME OF INSURANCE COMPANY:

_____

ADDRESS OF INSURANCE COMPANY:

_____

_____

POLICY#: _____ DOB: _____

NAME OF INSURED: _____

SSN: _____

DO YOU HAVE A SECOND PLAN?
☐ YES ☐ NO

NAME OF INSURANCE COMPANY:

_____

ADDRESS OF INSURANCE COMPANY:

_____

_____

POLICY#: _____ DOB: _____

NAME OF INSURED: _____

SSN: _____

CONSENT FOR TREATMENT

The above health history is complete and correct to the best of my knowledge. I authorize and give consent to perform dental services agreed between Doctor and Patient and/or Guardian to be necessary and advisable, including the use of local anesthesia and other medication as indicated. I agree that, regardless of insurance coverage, I am responsible for payment of services and that a finance charge of _____ % will be applied to accounts past sixty days.

Signature of Patient, Parent or Guardian: _____ Date: _____