NEW BRIGHTON FAMILY DENTISTRY

Welcome to our dental office. Please complete these 3 pages.

PATIENT INFORMATION: **TODAY'S DATE**:_____

Name:_____Preferred name_____ ( )Male ( )Female

Address:_____
Street Apt.# City State Zip

Telephone #:_____/_____/_____

Home Work Cell

Preferred Way to be Contacted (Home, work, cell or other):_____

E-mail Address:_____Birthdate:_____

Employer:_____Occupation:_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?:_____

PERSON RESPONSIBLE FOR ACCOUNT: ( )Self ( )Other_____

POLICY HOLDER INFORMATION:

Name:_____ Relation: (Self/Spouse/Parent) Birthdate:_____

Social Security #:_____ Employer:_____

Telephone:_____/_____/_____

Home Work Cell

DENTAL INSURANCE INFORMATION:

Dental Insurance Co.:_____ Group #:_____

Ins. Co. Address:_____ Telephone #:_____

Street City, State, Zip

PERSON TO CONTACT OUTSIDE OF IMMEDIATE FAMILY IN CASE OF EMERGENCY:

Name:_____ Phone #:_____

ACKNOWLEDGEMENT OF NOTIFICATION OF PRIVACY PRACTICES: ***You may refuse to sign this***

I, _____, have received a copy of this office's notice of privacy practices.

AUTHORIZATION:

I hereby authorize payment directly to New Brighton Family Dentistry of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize New Brighton Family Dentistry to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical and dental history pages are correct to the best of my knowledge.

SIGNATURE OF RESPONSIBLE PARTY:

X_____ Date:_____

( )Self ( )Parent ( )Spouse ( )Other

NEW BRIGHTON FAMILY DENTISTRY

DENTAL HISTORY

May we contact your previous dentist for records? ( )Yes ( )No. If yes, please list:

Name:_____ Telephone:_____

Address:_____

Do you have a specific dental problem? ( )Yes ( )No. If yes, Explain:_____

_____

Do you brush and floss on a routine basis? ( )Yes ( )No. If yes, how often?_____

What are your long-term dental health goals?_____

_____

What do you want your teeth to look like in 5 to 10 years?_____

_____

If you could change anything about your smile, what would you change?_____

_____

What concerns do you have, based on past experiences?_____

_____

Please circle any of the following if they apply to you now or in the past:

Chew on one side	Unpleasant taste	Teeth sensitive to pressure
Pain in or near ears	Dry mouth	Teeth sensitive to sweets
Jaw joint noise (clicking)	Mouth sores	Teeth sensitive to cold
Locked jaw	Gums bleed	Teeth sensitive to hot
Bite is off	Smoker	Difficult extractions
Clenching or grinding	Gum treatment	Prolonged bleeding after extraction
Bite fingernails	Had local anesthetic	Other:_____
Braces	(Novocaine)	

NEW BRIGHTON FAMILY DENTISTRY
MEDICAL HISTORY

Name: _____ Date_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ( )Yes ( )No
If yes, please explain:_____
Have you ever been hospitalized or had a major operation? ( )Yes ( )No
If yes, please explain:_____
Have you ever had radiation treatment to your head, neck, or jaw? ( )Yes ( )No
If yes, please explain:_____
Have you ever taken Fosamax, Boniva, Actonel or other meds containing bisphosphonates? ( )Yes ( )No
If yes, please explain:_____
Are you taking any blood thinners? (Coumadin/Warfarin, Heparin, Asprin, Etc) ( )Yes ( )No
If yes, please explain:_____
Are you taking medications, pills or drugs? ( )Yes ( )No
If yes, please explain:_____
Are you required to take a premedication before dental appointments, and have you taken your premed today? ( )Yes ( )No
If yes, please explain:_____
Do you use tobacco? ( )Yes ( )No
Do you snore or have sleep apnea? ( )Yes ( )No

WOMEN: Are you ( ) Pregnant / Trying to get pregnant? ( ) Nursing? ( ) Taking oral contraceptives?

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

( ) Aspirin	( ) Penicillin/Amoxicillin	( ) Clindamycin	( ) Acrylic
( ) Metal	( ) Latex	( ) Sulfa Drugs	( ) Local anesthetic

( ) Other allergies, Please explain:_____
Do you use controlled substances ( )Yes ( )No If yes, please explain:_____

DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

( ) AIDS/HIV Positive	( ) Cortisone Medicine	( ) Radiation Treatments	( ) Alzheimer's Disease
( ) Diabetes	( ) Anaphylaxis	( ) Drug Addiction	( ) Anemia
( ) Oral Herpes (Cold Sores)	( ) High Blood Pressure	( ) Rheumatism	( ) Arthritis/Gout
( ) Epilepsy or Seizures	( ) Artificial Heart Valve	( ) Excessive Bleeding	( ) Artificial Joint
( ) Blood Disease	( ) Kidney Problems	( ) Stomach/ Intestinal Disease	( ) Breathing Problem
( ) Liver Disease	( ) Stroke	( ) Cancer	( ) Lung Disease
( ) Thyroid Disease	( ) Chemotherapy	( ) Mitral Valve Prolapse	( ) Chest Pains
( ) Heart Attack/Failure	( ) Osteoporosis	( ) Tuberculosis	( ) Pain in Jaw Joints
( ) Tumors or Growths	( ) Congenital Heart Disorder	( ) Canker Sores	( ) Heart Pacemaker

Have you ever had any serious illness not listed ( ) Yes ( ) No If yes, please explain_____
_____

If you answered "yes" to any of the above please elaborate (including types of treatment you are seeking; severity of condition; INR, HbA1C, etc.) _____
_____

Signature:_____ Date: _____