ADULT NEW PATIENT INFORMATION

Full Legal Name: _____ Home Phone: _____

Preferred name (if different from legal name):_____ Cell Phone: _____

Social Security #:_____ Email Address: _____

Birth Date: _____ Please circle: Male/Female

Home Mailing Address: _____ City:_____ Zip: _____

Employer: _____ City: _____ Phone:_____

Marital Status: (please circle) S/M/D/W Spouse: _____ SS#: _____

Spouse's Employer:_____ City: _____ Phone: _____

If a dependant, responsible party's name and phone: _____

It is the policy of this office that charges are paid at the time of service. We will submit dental insurance claims but you are responsible for any charges your insurance does not cover. In addition, we require a 24-hour notice to cancel an appointment. If you have canceled or missed three appointments without providing 24-hour notice, we may no longer schedule you at this office.

Please sign below to accept policy & responsibility.

Signature: _____ Date: _____

Primary Dental Insurance Coverage

Subscriber: _____ SSN:_____ Birth Date:_____

Relationship to Patient:_____ Employer:_____

Insurance Company:_____ Group No.: _____

Secondary Dental Insurance Coverage

Subscriber: _____ SSN:_____ Birth Date:_____

Relationship to Patient:_____ Employer:_____

Insurance Company:_____ Group No.: _____

How did you hear about us and why did you choose TSDC for your dental care? _____

_____

When was your last dental visit?	X-Rays taken at last visit? Yes/No
Are you having any discomfort? Yes/No	If yes, please explain?
Have you had braces? Yes/No	If yes, when/for how long?
Are your teeth sensitive to hot & cold? Yes/No	If yes, explain:
Are your teeth sensitive to biting or chewing? Yes/No	
Ever had a serious injury to the face or mouth? Yes/No	If yes, explain:
Do your gums bleed or hurt when you brush? Yes/No	
Have you ever had gum disease? Yes/No	If yes, explain:

Do you often get sores/blisters in your mouth? Yes/No	

1) Are you in good health? Y/N 2)Date of last physical exam: _____
2) Primary Physician: _____ Phone: _____
3) Are you currently under medical care? Y/N If yes, please explain: _____
4) Have you ever had a serious illness or operation? Y/N If yes, please explain: _____

_____

5) Are you taking medication now? Y/N If yes, please fill out additional medication sheet.
6) Please check if you have or ever had any of the following:

Heart (Attack, Murmur, Surgery)	Diabetes	Venereal Disease
Chest Pain	Thyroid Problems	AIDS or HIV Positive
Congenital Heart Disease	Glaucoma	Cold Sores/Fever Blisters
High Blood Pressure	Emphysema (COPD)	Blood Transfusion
Mitral Valve Prolapse	Chronic Cough	Hemophilia
Artificial Heart Valve	Tuberculosis	Sickle Cell Disease
Heart Pacemaker	Asthma	Bruise Easily
Rheumatic Fever	Hay Fever/ Seasonal Allergies	Liver Disease
Arthritis(Rheumatoid or Osteo)	Latex Sensitivity/Allergy	Yellow Jaundice
Cortisone Medication (Steroids)	Allergies or Hives	Neurological Disorder
Stroke	Sinus Trouble	Epilepsy or Seizures
Diet Restrictions/Special Diet	Radiation Therapy	Fainting or Dizzy Spells
Artificial Joints (hip, knee, etc.)	Chemotherapy	Nervous/Anxious/Depression
Kidney Trouble	Tumors or Cancer	
Ulcers, Gastric Reflux	Hepatitis A, B, or C	

8) Do you have or have you had any disease, condition or problem not listed? Y/N

If yes, please explain: _____

9) Are you allergic to any medication? Y/N If yes, please list: _____
10) Do you smoke or chew tobacco? Y/N If yes, for how long/how much: _____
11) **Women**: Are you pregnant? Y/N If yes, due date: _____

Are you breastfeeding? Y/N Are you taking Birth Control Pills/Shots? Y/N

I understand the above information is necessary to provide me with dental care in a safe manner. I have answered all questions to the best of my knowledge. Should more information be needed, you have my permission to ask the respective health care provider or agency who may release information to you. I will notify the Dentist of any changes in my health or medications.

Patient/Guardian Signature: _____ Date: _____

Health History Reviewed			