New Patient Information

Patient Information:

Patient Name_____DOB _____Age___Gender_____
Address_____City_____State_____Zip_____
Home or Cell Phone Number_____Email_____
Patient's School/Occupation_____
Patient's General Dentist_____
Whom may we thank for referring you to our office?_____
PLEASE INFORM RECEPTIONIST OR DR. JONES OF LATEX ALLERGY

Person Responsible For Account:

Name_____Relationship to Patient_____
Birthday_____
Home Address_____City_____State_____Zip_____
Home Phone_____Ok to call?_____Leave a Message?_____
Employer_____Occupation_____
Work Phone_____Ok to call?_____Leave a message?_____
Cell Phone_____Ok to call?_____Leave a message?_____
Best number to call for Appt. reminders? H W C
Spouse Name_____Relationship to Patient_____
Does patient live with you?_____

Additional Person Responsible For Account:

Name_____Relationship to Patient_____
Birthday_____
Home Address_____City_____State_____Zip_____
Home Phone_____Ok to call?_____Leave a Message?_____
Employer_____Occupation_____
Work Phone_____Ok to call?_____Leave a message?_____
Cell Phone_____Ok to call?_____Leave a message?_____
Best number to call for Appt. reminders? H W C
Spouse Name_____Relationship to Patient_____
Does patient live with you?_____

Dental History:

Have you ever had a habit of sucking your fingers/thumb? Yes No If yes, until what age?___
Do you have any speech problems? Yes No
Have you been informed of any missing or extra permanent teeth? Yes No
Have you consulted with an orthodontist previously? Yes No
Did either of your parents have orthodontic treatment? Yes No
Do you have popping, cracking or pain in or around the jaw joint? Yes No If yes, when did this begin?_____
When was your last appointment with a general dentist?_____ Purpose of visit?_____

(More questions on the back side of page)

Medical History:

Are you in good health? Yes No_____

Do you have a history of any major illness? Yes No If yes, please explain_____

Have you had any past surgeries? Yes No If yes, please explain_____

Your Physician's

Name_____

Have you had tonsils and adenoids removed? Yes No If yes, then at what age?_____

Please list any allergies that you have_____

Please list any medications you are currently taking and reason_____

Have you ever had an injury involving the face, mouth or teeth? Yes No

Circle any of the following conditions that apply to you:

Glaucoma	Kidney disorders	Typhoid fever	HIV
Diabetes	Endocrine disorders	Hepatitis	Malignancies
Pneumonia	Prolonged bleeding	Measles	Mumps
Asthma	Fainting or dizziness	Scarlet fever	Tonsillitis
Rheumatic fever	Nervous disorders	Arthritis	Stroke
Bone disorders	Psychiatric disorders	Epilepsy	Low blood pressure
Tuberculosis	Ulcers	Radiation treatments	High blood pressure
Sinus problems	Circulatory problems	Anemia	Heart trouble
Transfusion			

Women:

Are you pregnant? Yes No

Dental Insurance Information (Please include Wy Medicaid and Wy Kid Care Chip):

Name of Insured_____SSN of Insured____-___-_____ DOB_____

Employer_____Policy Number/Member ID_____

Insurance Company_____Group Number_____

Insurance Company Address_____Phone #_____

Do you have Dual Coverage? Yes No If Yes:

Name of Insured_____SSN of Insured____-___-_____ DOB_____

Employer_____Policy Number/Member ID_____

Insurance Company_____Group Number_____

Insurance Company Address_____Phone #_____

SIGNATURE_____ DATE_____

PRINT NAME_____