Tel (480) 508-6501
Fax (480) 758-5789

Info@McDowellSmiles.com
McDowellSmiles.com

McDowell Smile Life Dentistry

New Patient Information Form

I would like to take the time and welcome you to our practice. We thrive to provide you with the best quality care, and to do so, we would love to know a little bit more about you. We are here to help, so if you require any assistance, please do not hesitate to ask one of our fantastic patient service representatives.

First Name: _____ Date of Birth

Middle Name: _____

Last Name: _____ Gender Male Female

Mobile Phone Number _____

Email Address _____

Home Address _____ _____

City _____ State _____ Zip Code_____

Preferred method of contact Email Text Phone Call

Preffered Language English Farsi Spanish

Dental Insurance Info. If you do not have any, please move on to the next section

Insurance Carrier _____

Subscriber Name _____

Subscriber ID number (we might need your social security information if you do not know the ID number/Card) _____

Group Number: _____

Subscribers Employer if any _____

Emergency Contact

Name _____ Phone Number _____

Relationship _____

Do you suffer from any of the following conditions?

	Y	N		Y	N
Diabetes			**Bleeding Disorder**		
Heart Condition			**Ulcers**		
High Blood pressure			**Liver Disease**		
Stroke			**Kidney Disease**		
Heart Attach			**Psychiatric Care**		
Heart Murmur			**Asthma**		
Joint replacement			**Sinus Trouble**		
Chronic Headaches					

Please tell us if you are allergic to any of the following

	Y	N		Y	N
Aspirin/Ibuprofen			**Vicodin**		
Amoxicillin/Penicillin			**Clindamycin**		
Epinephrine			**Iodine / shellfish**		
Anesthetic			**Latex**		
Please list any other allergies that are not listed above					

Are you currently or have you ever taken any of the following medications

	Y	N		Y	N
Coumadin \Warfarin			**Bisphosphonate**		
Aspirin			**Actonel**		
Other blood thinners			**Boniva**		
Plavix			**Fosomax**		
Please List any other Medications you are taking now					
_____	_____	_____			
_____	_____	_____			
_____	_____	_____			

What brings you in to our office today?	_____
Do you have any pain?	_____
If yes how would you describe your pain?	_____
Are you happy with your smile?	_____
Do you smoke Or Chew Tobacco	_____

Are you interested in any of the following? Would you like Dr. Rouhani to discuss these with you?

	Y	N		Y	N
Dental whitening			**In Office Whitening**		
Replacement of missing teeth			**Dental Implants**		
Dentures			**Dentures over implants**		
Orthodontics			**Invisalign / Clear Aligners**		
Cosmetic Dentistry			**Veneers**		

Please verify that all the information that you have given is true to the best of your knowledge and that you have been given the chance to ask for help or to ask any questions.

Name of Person Filling out the form _____
Relationship to the patient _____
Today's Date _____