ALL Care DENTAL

New patient form

FOR A PATIENT 18 OR OLDER

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Please print clearly, or type into this form on screen and then print it.
Bring it with you to your first visit.

OFFICE USE · CHART NO.	MEDICAL ALERT

ABOUT YOU

LAST NAME	TITLE	GIVEN NAMES	TODAY'S DATE
	○ Mr ○ Mrs ○ Ms ○ Dr		

APT.	STREET ADDRESS	CITY	POSTAL CODE

DATE OF BIRTH (MM / DD / YYYY)	HOME PHONE	CELL PHONE	EMAIL

OCCUPATION	EMPLOYER	BUSINESS PHONE

IN CASE OF EMERGENCY, NOTIFY	RELATIONSHIP	PHONE

PERSON RESPONSIBLE FOR YOUR ACCOUNT	WHOM MAY WE THANK FOR REFERRING YOU?
○ Self ○ Other: _____	

FAMILY PHYSICIAN	PHONE	PREVIOUS DENTIST	ADDRESS OR PHONE

DENTAL INSURANCE

DO YOU HAVE DENTAL INSURANCE?	NAME OF INSURED EMPLOYEE	INSURANCE COMPANY	EMPLOYER
○ Yes ○ No			

GROUP POLICY NUMBER	CERTIFICATE OR ID NUMBER	POLICY HOLDER'S DATE OF BIRTH

MEDICAL HISTORY · confidential

		YES	NO
1.	Are you in good health?	○	○
2.	Are you under the care of a physician at present?	○	○
3.	Have you ever had a serious illness or operation, or been in hospital?	○	○
	If yes, please give details: _____		
4.	Are you taking any medicines or drugs at present?	○	○
	A _____ B _____ C _____		
	D _____ E _____ F _____		
5.	Have you ever had rheumatic fever?	○	○
6.	Have you ever had hepatitis or jaundice?	○	○
7.	Do you have a heart murmur?	○	○
8.	Do you bruise easily, or have prolonged bleeding?	○	○
9.	Have you ever had a reaction to any kind of medicine?	○	○
	To: ☐ Penicillin ☐ Sulfa drugs ☐ Aspirin, Advil or similar ☐ Codeine Other: _____		
10.	Do you have any other allergies, including latex? If yes, to what? _____	○	○
11.	Have you ever taken cortisone or steroids?	○	○
12.	Do you have an artificial hip or heart valve (a prosthesis)?	○	○
13.	Do you have sudden chest pains?	○	○
14.	Are you short of breath after very little effort?	○	○
15.	Have you ever fainted?	○	○
16.	Are you pregnant? If yes, when is your baby due? _____	○	○

17. Do you have, or have you ever had, any of the following?

☐ HIV or AIDS	☐ Arthritis	☐ Asthma	☐ Blood disorder
☐ Cancer	☐ Diabetes	☐ Epilepsy	☐ Heart disease
☐ High or low blood pressure	☐ Kidney disease	☐ Liver disease	☐ Lung disease
☐ Skin disorder	☐ Thyroid problem	☐ Tuberculosis	☐ Sexually transmitted infection

ALL Care DENTAL

Patient name _____

DENTAL HISTORY

		YES	NO
1.	What is the reason for today's visit? ☐ Examination ☐ Emergency ☐ Other: _____		
2.	Date of your last dental visit: _____		
3.	Have you ever had instruction in cleaning your teeth? ☐ Brushing ☐ Flossing ☐ Other: _____		
4.	Have you ever had a local anesthetic (freezing)?	○	○
	Any complications? Please describe: _____		
5.	Have you ever had a full-mouth series of X-rays?	○	○
6.	Have you had any of the following?		

☐ Loose teeth ☐ Cavities ☐ Gum disease ☐ Sensitive teeth
☐ Bleeding gums ☐ A bad taste in your mouth ☐ A clicking or sore jaw ☐ Earaches or headaches
☐ Unsightly or broken fillings ☐ Dead or abscessed teeth

7.	Does your jaw crack, pop or grate when you open wide?	○	○
8.	Do you grind or clench your teeth?	○	○
9.	Have you ever had any of these dental treatments?		

☐ Bridgework ☐ Cleaning ☐ Crowns or caps ☐ Dental X-rays
☐ Extractions ☐ Fillings ☐ Full or partial dentures ☐ Orthodontics (braces)
☐ Gum (periodontal) treatment ☐ Root canal

10.	Have you ever had a problem with previous dental treatment?	○	○
	If yes, please describe: _____		
11.	Are you satisfied with the appearance of your teeth?	○	○
	If not, what would you change? _____		
12.	In your own words, describe your present dental problems:		

_____

_____

_____

OFFICE POLICY

- To plan the treatment that is best for your overall dental health, we must first make a careful diagnosis. That means a thorough examination, using the fewest X-rays needed for an accurate result.
- We pledge to provide high-quality dentistry as comfortably as possible, with up-to-date equipment, materials and techniques.
- Your appointment time is reserved for you. If you cannot keep it, we need 24 hours' notice; otherwise we will charge for the time lost.
- Our policy is that services are paid for at each visit, as they are performed. In some circumstances a payment arrangement can be made with the dentist or the office manager.
- **Insurance.** Every patient with dental insurance is responsible for paying their own account. We can bill your insurer directly if your plan allows it. Please make sure you understand the limits of your dental plan; we will gladly send in estimate forms if needed.
- A good relationship between dentist and patient rests on mutual respect and understanding. Please feel free to talk to us about any part of your treatment or fees, at any time.

PATIENT CERTIFICATION AND CONSENT

A parent or guardian signs for a patient under 18.

I certify that the medical and dental information above is true to the best of my knowledge, and that I have not left out anything relevant. I consent to the dental and oral procedures agreed to be necessary or advisable, and I accept responsibility for the fees for these procedures.

DATE _____ SIGNATURE OF PATIENT, OR PARENT OR GUARDIAN _____

NAME OF PARENT OR GUARDIAN (IF SIGNING FOR A PATIENT UNDER 18) _____ RELATIONSHIP TO THE PATIENT _____

This form holds personal health information. All Care Dental keeps it confidential and uses it to care for you and, when you ask us to, to send claims to your insurer. Please hand it in at the office rather than emailing it.