New Patient Form/Update of Patient Information

Last Name _____, First Name _____ Middle Name:_____
Parent/Guardian's Name:_____
Address: _____ Spouse's Name:_____
City, State, Zip: _____

Phone #'s	Home	Work	Cell
1st Preference _____	☐	☐	☐
2nd Preference:_____	☐	☐	☐

Email Address: _____

Sex
☐Male ☐ Female

Marital Status
☐ Single ☐ Married ☐ Divorced ☐ Widowed

Social Security # _____

Birth date: _____

Whom may we thank for referring you to our office? _____
☐ Yellow Pages ☐ TV ☐ Billboard ☐ Friend/Family ☐ Location ☐ Employee ☐ Insurance Co. ☐ Other

What is your reason for seeking dental treatment today? _____
_____

Previous Dentist's Name _____ City_____ State_____
How long has it been since your last dental appointment? : _____ Were Oral X-Rays taken? ☐ Yes ☐ No

Patient's PRIMARY Dental Insurance:
Employer Name: _____ Employee name: _____
Insurance Company: _____ ID#: _____
Group #: _____ Soc Security of Insured: _____
Birth date of Insured: _____ Medical Insurance Co: _____

Patient's SECONDARY Dental Insurance: (if listed on spouse's dental policy)
Employer: _____ Employee: _____
Insurance Company: _____ ID#: _____
Group #: _____ Soc Security of Insured: _____
Birth date of Insured: _____ Medical Insurance Co: _____

Pharmacy Name:_____ Phone: _____

In Case of Emergency, contact: Name:_____ Phone: _____
(please specify someone who is NOT in same household)

Authorization and Release

I authorize Bentleyville Sedation Dentistry, P.C. to file claims to my insurance company and to use the signature below as my authorized signature for claims of dental/medical benefits for the above provider and patient for professional services rendered. I also authorize the release of any of my medical records necessary or requested for the processing of related insurance claims.

I acknowledge that a copy of this office's Notice of Privacy Practices for Protected Health Information (HIPAA) containing a description of the uses and disclosures of my personal and health information has been made available to me.

I hereby authorize Bentleyville Sedation Dentistry, P.C. to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental/medical care.

I am the: (check one)
☐ **Adult Patient**
☐ **Parent**
☐ **Guardian**

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medications change, I will inform the dentist at the next appointment without fail. By signing below I also agree to be responsible for payment of all services rendered to the patient named above.

Signature: _____ **Date:** _____

Health History Patient Name: _____

1. Have you ever experienced any of the following? (please check)

Y/ N Conditions	Y/ N Conditions	Y /N Conditions
☐☐ Abnormal Bleeding	☐☐ Epilepsy	☐☐ Osteoporosis
☐☐ Alcohol Abuse	☐☐ Fainting Spells	☐☐ Pace Maker
☐☐ Allergies	☐☐ Frequent Headaches	☐☐ Pneumocystitis
☐☐ Anemia	☐☐ Glaucoma	☐☐ Psychiatric Problems
☐☐ Angina Pectoris	☐☐ Gout	☐☐ Radiation Therapy
☐☐ Arthritis	☐☐ HIV+ AIDS	☐☐ Rheumatic Fever
☐☐ Artificial Heart Valve	☐☐ Heart Arrhythmia	☐☐ Seizures
☐☐ Asthma	☐☐ Heart Attack	☐☐ Shingles
☐☐ Blood Transfusion	☐☐ Heart Surgery	☐☐ Sickle Cell Disease
☐☐ Cancer-Chemotherapy	☐☐ Hemophilia	☐☐ Sinus Problems
☐☐ Colitis	☐☐ Hepatitis A, B or C	☐☐ Stroke
☐☐ Congenital Heart Defect	☐☐ High Blood Pressure	☐☐ Thyroid Problems
☐☐ Cosmetic Surgery	☐☐ Joint Replacement	☐☐ Tuberculosis
☐☐ Diabetes	☐☐ Kidney Problems	☐☐ Ulcers
☐☐ Difficulty Breathing	☐☐ Liver Disease	☐☐ Venereal Disease
☐☐ Drug Abuse	☐☐ Low Blood Pressure	☐☐ Yellow Jaundice
☐☐ Emphysema	☐☐ Mitral Valve Prolapse	

Do you have any other conditions / problems not covered above? Yes ☐ No ☐
If yes, please describe:

2. Are you under a physician's care? Yes ☐ No ☐

Physician's Name: _____ Physician's Phone #: _____

3. Please list all Prescription and Non-Prescription medication | Why do you take each medication?

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

If you need more room, please ask for our longer form.
You may also bring us a photocopy your medications, if you prefer.

4. Do you have any Allergies? No ☐ Yes ☐
(if yes, please check below)

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Jewelry
- ☐ Latex
- ☐ Metals
- ☐ Penicillin
- ☐ Tetracycline

Other:

5. Miscellaneous

Yes	No	
☐	☐	Do you smoke or use tobacco?

Height: _____ Weight: _____

6. For women only…

Yes	No	
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregnant?
☐	☐	Are you nursing?

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Patient (or Parent/Guardian) Signature: _____ **Date:** _____
(Please Print Name): _____