SIGNATURE DENTAL
FAMILY DENTISTRY

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NEW PATIENT FORM

The following information is required by our office to thoroughly diagnose any condition and give you personal attention. This form is STRICTLY CONFIDENTIAL. *Please fill out the form completely.*

Personal Information

NAME		DATE OF BIRTH
ADDRESS		POSTAL CODE
HOME PHONE	CELL PHONE	EMAIL
OCCUPATION	EMPLOYER	WORK PHONE

HOW WOULD YOU LIKE TO BE CONTACTED? (*List in order, e.g. Cell, Work, Home, Email*)	PERSON RESPONSIBLE FOR YOUR ACCOUNT
IF CHILD, NAME OF MOTHER	IF CHILD, NAME OF FATHER

Dental Insurance

NAME OF INSURANCE PLAN	I.D. # or CERTIFICATE #	POLICY HOLDER'S EMPLOYER	DENTAL PLAN HOLDER'S NAME
POLICY OR PLAN NUMBER	DEPENDENT NUMBER	COVERAGE A B C Plan Max	PLAN HOLDER'S DATE OF BIRTH

Medical History

PERSONAL PHYSICIAN	PHONE #
CLINIC LOCATION / ADDRESS	

Do you have OR have you ever had (*Select all that apply*)

☐ 1. hospitalization for illness or injury

2. an allergic reaction to:
   - ☐ aspirin, ibuprofen, acetaminophen
   - ☐ penicillin
   - ☐ erythromycin
   - ☐ tetracycline
   - ☐ codeine
   - ☐ local anesthetic
   - ☐ fluoride
   - ☐ metals (gold, stainless steel)
   - ☐ latex
   - ☐ any other medications

   _____

☐ 3. to take antibiotics prior to a dental procedure

☐ 4. heart problems / defect / pacemaker

☐ 5. heart murmur / ventricular prolapse

☐ 6. rheumatic fever / scarlet fever

☐ 7. high blood pressure

☐ 8. low blood pressure

☐ 9. a stroke

☐ 10. artificial prosthesis *(e.g. joints, stents, heart valve)* Date: _____

☐ 11. anemia or other blood disorder

☐ 12. abnormal bleeding

☐ 13. emphysema

☐ 14. tuberculosis

☐ 15. asthma

☐ 16. breathing or sleep problems *(snoring, sinus, sleep apnea)*

☐ 17. sinus problems

☐ 18. kidney disease

☐ 19. liver disease

☐ 20. jaundice

☐ 21. thyroid or parathyroid disease

☐ 22. hormone deficiency

☐ 23. high cholesterol

☐ 24. diabetes (*circle*): Type 1 Type 2

☐ 25. stomach or duodenal ulcer

☐ 26. digestive disorders (gastric reflux)

☐ 27. eating disorders (anorexia/bulimia)

Do you have OR have you ever had (*select all that apply*)

- ☐ 28. osteoporosis/osteopenia (taking bisphosphonates)
- ☐ 29. arthritis
- ☐ 30. glaucoma
- ☐ 31. contact lenses
- ☐ 32. head or neck injuries
- ☐ 33. epilepsy, convulsions (seizures)
- ☐ 34. neurologic problems / alzheimers / memory loss
- ☐ 35. viral infections and cold sores
- ☐ 36. any lumps or swelling in the mouth
- ☐ 37. dry mouth
- ☐ 38. hives, rash, hay fever
- ☐ 39. venereal disease
- ☐ 40. hepatitis (type_____)
- ☐ 41. HIV / AIDS
- ☐ 42. tumor, abnormal growth
- ☐ 43. radiation therapy
- ☐ 44. chemotherapy
- ☐ 45. emotional problems
- ☐ 46. psychiatric treatment
- ☐ 47. antidepressant medication
- ☐ 48. alcohol / drug dependency

Are you: (*Select all that apply*)

- ☐ 49. presently being treated for any other illness
- ☐ 50. aware of a change in your general health
- ☐ 51. often exhausted or fatigued
- ☐ 52. subject to frequent headaches
- ☐ 53. a smoker, smoked previously, use tobacco
- ☐ 54. Female – taking birth control pills
- ☐ 55. Female – pregnant /nursing
- ☐ 56. Male – prostate disorders

Additional Medical Information

_____

_____

List all medications, supplements, and/or vitamins.

Medication	Reason for taking

Dental History

WHAT IS YOUR IMMEDIATE DENTAL CONCERN? (*Briefly describe*)

_____

_____

I hereby certify that the information given here is complete, true and correctly recorded, and I consent to examination and treatment agreed to be necessary or advisable. Additionally, I authorize Signature Dental to make inquiries to my dental insurance company on my behalf, submit claims electronically, and authorize payments as directed.

_____ _____

Signature of Patient (or Parent / Guardian) Date