Roseville Smiles Family Dentistry
New Patient Form (Adult)

Patient Information

Today's Date: _____

Name: _____
Last First Mi Mr Mrs Ms Dr

Birthdate: _____ Age: ____ SSN: _____

☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Home Address: _____
Address City State Zip Code

Phone (home): _____ Phone (cell): _____

Phone (work): _____

E-Mail Address: _____

Employer: _____

Employer Address: _____

How long there? _____ Occupation: _____

Where & when are the best time to reach you? _____

How did you find about us? ☐Referral ☐Online ☐Ad ☐Friend ☐Other _____

Other family members seen by us: _____

☐Previous ☐Present Dentist:

Last Visit Date: _____

Spouse Information

Name: _____
Last First Mi Mr Mrs Ms Dr

Birthdate: _____ Age: ____ SSN: _____

Phone (cell): _____ Phone (work): _____

Employer: _____

Person Responsible for Account

Name: _____
Last First Mi Mr Mrs Ms Dr

Birthdate: _____ Age: ____ SSN: _____

Phone (cell): _____ Phone (work): _____

Billing Address: _____

Relationship: _____

Employer: _____

Insurance

Primary Insurance

Dental Coverage? ☐Yes ☐No

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____

Group Nr (Plan, Local or Policy Nr): _____

Primary Insurance (continued)

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's ID Nr: _____

Insured's Employer: _____

Employer's Address: : _____

Secondary Insurance

Dental Coverage? ☐Yes ☐No

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____

Group Nr (Plan, Local or Policy Nr): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's ID Nr: _____

Insured's Employer: _____

Employer's Address: : _____

Medical History

Do you have a personal physician: ☐Yes ☐No

Physician's Name: : _____

Phone: _____ Date of last visit: _____

Are you currently under the care of a physician: ☐Yes ☐No

Please explain: _____

Your current physical health: ☐Good ☐Fair ☐Poor

Do you smoke or use tobacco in any other form? ☐Yes ☐No

Have you had any metal rods, pins or implants? ☐Yes ☐No

Are you taking any prescription / over-the counter or herbal supplemental drugs? ☐Yes ☐No

Please list: : _____

Have you ever taken Fosamax, or any other bisphosphonate? ☐Yes ☐No

Have you ever taken Phen-Fen? ☐Yes ☐No

For Women

Are you using a prescribed method of birth control? ☐Yes ☐No

Are you pregnant? ☐Yes ☐No Week #: _____

Are you nursing? ☐Yes ☐No

Have you ever had any of the following diseases or medical problems

☐Yes	☐No	Abnormal Bleeding	☐Yes	☐No	Herpes / Fever Blisters
☐Yes	☐No	Alcohol / Drug Abuse	☐Yes	☐No	High Blood Pressure
☐Yes	☐No	Anemia	☐Yes	☐No	HIV+ / AIDS
☐Yes	☐No	Arthritis	☐Yes	☐No	Hospitalized For Any Reason
☐Yes	☐No	Artificial bones / Joints / Valves	☐Yes	☐No	Kidney Problems
☐Yes	☐No	Asthma	☐Yes	☐No	Liver Disease
☐Yes	☐No	Blood Transfusion	☐Yes	☐No	Low Blood Pressure
☐Yes	☐No	Cancer / Chemotherapy	☐Yes	☐No	Lupus
☐Yes	☐No	Colitis	☐Yes	☐No	Mitral Valve Prolapse

☐Yes	☐No	Congenital Heart Defect	☐Yes	☐No	Osteoporosis / Paget/s Disease
☐Yes	☐No	Diabetes	☐Yes	☐No	Pacemaker
☐Yes	☐No	Difficulty Breathing	☐Yes	☐No	Psychiatric Problems
☐Yes	☐No	Emphysema	☐Yes	☐No	Radiation Treatment
☐Yes	☐No	Epilepsy	☐Yes	☐No	Rheumatic / Scarlet Fever
☐Yes	☐No	Fainting Spells	☐Yes	☐No	Seizures
☐Yes	☐No	Frequent Headaches	☐Yes	☐No	Shingles
☐Yes	☐No	Glaucoma	☐Yes	☐No	Sickle Cell Disease / Traits
☐Yes	☐No	Hay Fever	☐Yes	☐No	Sinus Problems
☐Yes	☐No	Heart Attack	☐Yes	☐No	Stroke
☐Yes	☐No	Heart Murmur	☐Yes	☐No	Thyroid Problems
☐Yes	☐No	Heart Surgery	☐Yes	☐No	Tuberculosis (TB)
☐Yes	☐No	Hemophilia	☐Yes	☐No	Ulcers
☐Yes	☐No	Hepatitis	☐Yes	☐No	Venereal Disease

Please list any serious medical condition(s) that you have ever had:_____

_____

_____

Are you allergic to any of the following:

☐Yes	☐No	Aspirin	☐Yes	☐No	Erythromycin
☐Yes	☐No	Tetracycline	☐Yes	☐No	Codeine
☐Yes	☐No	Latex	☐Yes	☐No	Penicillin
☐Yes	☐No	Dental Anesthetics	☐Yes	☐No	Other

Please list any other drugs / materials that you are allergic to:_____

_____

Dental History

Why have you come to the dentist today?

Do you require antibiotics before dental treatment? ☐Yes ☐No

Are you currently in Pain? ☐Yes ☐No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐Yes ☐No

Do you have fears about going to the dentists? ☐Yes ☐No

Have you ever had gum treatment? ☐Yes ☐No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐Yes ☐No

Your current dental health: ☐Good ☐Fair ☐Poor

Do your gums ever bleed? ☐Yes ☐No

How many times a day do you floss / brush? Floss _____ times a day. Brush _____ times a day.

Type of bristles? ☐Soft ☐Medium ☐Hard

How long do you use a toothbrush before replacing it? _____

Are your teeth sensitive to heat, cold, or anything else? _____

Have you lost any teeth? ☐Yes ☐No If yes, why? _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

_____

Signature

Payment is due in full at the time of treatment unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials:_____ Date: _____

Doctor's Comment: _____

_____

Medical History Update

I have read my medical history dated_____and confirmed that it states past and present medical conditions. _____
Signature

I have read my medical history dated_____and confirmed that it states past and present medical conditions. _____
Signature

I have read my medical history dated_____and confirmed that it states past and present medical conditions. _____
Signature