NEW PATIENT INFORMATION FORM **DATE:**

NAME (Last, First, Middle):________________________________ TITLE: ___________

HOME ADDRESS: ____

PREFERRED NAME: _______________________SS :_____-_____-_____ D.O.B.__/__/__

HOME PHONE: ________________ SEX: M / F WORK PHONE:________________

EMPLOYER: ____________________________________ MARITAL STATUS: S/M/D/W

CELL PHONE/PAGER: ________________ EMAIL:_________________________________

EMERGENCY CONTACT: NAME: ______________________ PHONE:____________________

PRIMARY DENTAL INSURANCE COVERAGE

SUBSCRIBER NAME: ____________________________ RELATION TO PATIENT:__________

SUBSCRIBER'S D.O.B.____/_____/____ SS# _____-______-_____ GROUP#__________

EMPLOYER:________________________ INS. CO. PHONE #_________________________

INSURANCE CO:____

ADDRESS:____

SECONDARY DENTAL INSURANCE COVERAGE

SUBSCRIBER NAME: ____________________________RELATION TO PATIENT: _____________

SUBSCRIBER'S D.O.B.____/_____/____ SS# _____-______-______ GROUP#__________

EMPLOYER: ______________________________ INS. CO. PHONE #____________________

INSURANCE CO: ____

ADDRESS: ____

RESPONSIBLE PARTY:
Name and Address: ____

SIGNATURE:____

HEALTH HISTORY

Name ______________________________________ Date ____________________

Date of last health care exam: ____________ What was this exam for? ____________________

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason: ____

Are you currently receiving care? No Yes If yes, nature of care: ____________________

Please list all the names and phone numbers of the physicians or alternative healthcare practitioners who are currently providing you care:

1. ________________________________
2. ________________________________
3. ________________________________
4. ________________________________

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Heart Murmur (mitral valve prolapse)	No	Yes	Psychosis	No	Yes
Anemia	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Slow-Healing Mouth Sores	No	Yes
Hepatitis, Any Form	No	Yes	Tuberculosis	No	Yes
Rheumatic Fever	No	Yes	Recurrent Illnesses	No	Yes
Asthma	No	Yes	Joint Replacement	No	Yes
HIV Positive or AIDS Related Complex	No	Yes	Glaucoma	No	Yes
Emphysema or Respiratory Illnesses	No	Yes	Abnormal Bleeding from a cut	No	Yes
Abnormal Heart Condition	No	Yes	Liver Disease (including Jaundice)	No	Yes
Kidney Disease	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart (Surgery, Disease, Attack)	No	Yes	Latex Sensitivity	No	Yes
Venereal Disease	No	Yes	Taken Fen-phen or other diet pills	No	Yes
Thyroid Problems	No	Yes	Arthritis	No	Yes
Cancer (current or past)	No	Yes	Other:	No	Yes

Are you required to Pre-Medicate before dental treatment? No Yes

Women: Are you pregnant? No Yes
If no, are you planning a pregnancy in the near future? No Yes
Are you a nursing mother? No Yes
Are you taking birth control pills? No Yes

Abnormal Blood Pressure? (Please circle) No Yes
If yes, what is it usually: S /D

Are you allergic or have you had a reaction to:

a. Local anesthetics .... No Yes
b. Penicillin or other antibiotics .... No Yes
c. Aspirin .... No Yes
d. Codeine, valium or other sedatives.. No Yes
e. Other ________________________________

Are you a smoker? No Yes
If so, how much do you smoke per day? ______________

Please list any medications you are currently taking:

1. ____________________ 2. ____________________
3. ____________________ 4. ____________________
5. ____________________ 6. ____________________

Are you taking Tagamet (Cimetidine)? No Yes If yes, how often? ____________________

Do you take Antacids? No Yes If yes, how often? ____________________

Have you ever taken Fosamax, Boniva, Actenol or any other medications containing bisphosphonates? No Yes

Do you take, or have you taken Phen-Fen or Redux No Yes

Are you taking any herbal supplements/medicines? No Yes If yes, which ones?________________

Diet: Restricted Diet ____________________
How many meals a day ____________________
Food Allergies ____________________
Sugar in your diet: ❑ None ❑ Slight ❑ Moderate ❑ High

Would you like a whiter smile? If you could change one thing about your smile, what would that be?
____

Are you interested in avoiding bad breath? ____________________

Are you interested in a non-surgical way of stopping your spouse from snoring? ____________________

Are you anxious before dental appointments or concerned about the way you will feel after treatment?
(Please explain) ____________________
____

Do you have a history of pain in your jaw joint (TMJ) or joint noises and dysfunction (TMD)?
(Please explain) ____________________
____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

Patient (Print Name)	*Patient Signature*	*Date*
Doctor/Hygienist (Print Name)	*Doctor/Hygienist Signature*	*Date*

DOCTOR'S USE ONLY

Comments on patient interview concerning medical history:
____
____

Significant findings from questionnaire or oral interview:
____
____

Dental management considerations:
____
____

Dental History

Welcome! So that we may provide you with the best possible care, please complete this dental history form. All information is completely confidential. Thank you.

*Name:*_______________________________________

What is the reason for your visit today?

When was your last Dental office visit? Last Dental cleaning?

Last Full Mouth X-rays?

What was done at your last Dental visit?

Previous Dentist's Name: Address:

Phone number:

How often do you have dental examinations?

How often do you brush your teeth? How often do you floss?

What other dental aids do you use? (Sonicare, Oral B Braun, Waterpik, bridge threader, etc.):

Are you having any dental problems now? Yes No

If yes, please describe:

Would you like to keep all of your teeth, all of your life? Yes No

Do you feel nervous about having dental treatment? Yes No

Tell us about your best dental experience:_____________________________

____

____

How can we help you have a pleasant experience here? (headphones, explain procedures, give you a hand mirror, others ideas?)___________________________________

____.

Is there anything else about having dental treatment you'd like us to know? Yes No

If yes, please describe:____

____.

Do you see any alternative healthcare providers? Yes No

(For example: Naturepath, Osteopath, Acupuncturist,Chiropractor)

Dental History 2.

Name ______________________________

Are you satisfied with your teeth's appearance? Yes No

If not, what would you like to change about their appearance?_________

____.

Are any of your teeth sensitive to?:

Hot or cold Yes No

Sweets Yes No

Biting or Chewing Yes No

Noticed any bad odors Yes No

Hold foreign objects with teeth (pens, pencils, nails, fingernails) Yes No

Do your gums bleed/hurt? Yes No

Have your parents experienced

Gum disease? Yes No

Tooth loss? Yes No

Does food tend to become caught in between your teeth? Yes No

Where?_______________________.

Do You:

Clench/Grind your teeth? Yes No

While awake? Yes No

While asleep? Yes No

Mouth breathe? Yes No

Do you:

Smoke/Chew tobacco? Yes No

Notice your jaws are tired, especially in the morning? Yes No

Have you ever had?:

Orthodontic treatment Yes No

Oral surgery Yes No

Periodontal treatment Yes No

Have you experienced?

Clicking or popping of the jaw Yes No

Pain(joint, ear, side of face) Yes No

Difficulty in opening or closing the mouth

Your teeth ground or your bite adjusted Yes No

Headaches, neckaches or shoulderaches Yes No

A serious injury to the mouth or head Yes No

If yes, please describe including cause and when________________________________

____

____.

PATIENT AGREEMENT

I agree to be responsible for keeping all scheduled appointments. If I am unable to keep my appointment, I agree to call the office to cancel 48 hours ahead so that someone else may have that time.
(Initials________)

I agree that if I fail my scheduled appointment or cancel within less than 48 hours of my appointment, I will be given a one time courtesy credit for that missed appointment. If this happens again, I will be charged $70.00. I agree to pay this amount. I understand that insurance cannot be billed for this amount. I am responsible.
(Initials________)

I understand that payment is due in full at the time services are rendered unless other arrangements are made in advance.
(Initials________)

I agree that if my insurance is cancelled or if they do not cover a particular service, I am financially responsible. I understand that your office will do the best to get the maximum possible coverage for me but that any amount not covered by insurance will ultimately be my responsibility.
(Initials________)

Patient Name____

Date Signed____

AUTHORIZATION TO RELEASE DENTAL RECORDS

In accordance with HIPAA and ADA regulations, I hereby authorize:

Sarah Wilsey DDS
1600 Sir Francis Drake Blvd.
San Anselmo, CA 94960
415-456-5114

To release a photocopy or email of my dental treatment records and originals or duplicates of any current x-rays to the dental office of:

Patient's Name:____

Date of Birth:____

Patient Signature:_______________________________________Date:___________________
(Parent or legal guardian must sign if patient is minor)

FOR OFFICE USE ONLY

Request sent on____________________________________

Request received on_________________________________

Date sent____

Records and xrays to be sent or emailed to ____
____
____