NEW PATIENT INFORMATION SHEET

PERSONAL INFORMATION Date ____________

First Name ________________________ Middle Initial _____ Last Name ____________________________
(Circle one) Mr. Mrs. Ms. Dr. Physical Address____
City _____________________ State _____ Zip Code ___________
P.O. Box___________________________
City _____________________ State _____ Zip Code ___________ Home Phone _________________________
Work Phone ____________________ Ext. __________ Cell Phone _____________________________

Birth date ______/______/______ Social Security Number _______/______/_________ Gender M F
E-mail Address ________________________ Employer __________________Employer phone_______________
Spouse/Parent's Name __________________SS#____/____/________ Employer__________________
Employer phone_____________
Person responsible for account __________________________________ Relationship ______________________
Emergency Contact ____ Relationship ______________________
Home Phone _______________________ Work Phone __________________ Ext. _______________________
How did you hear about us? ____

Are your visits covered by: ☐ dental insurance ☐ medical insurance ☐ both ☐ none

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PRIMARY DENTAL INSURANCE INFORMATION

Policy Holder's Name __________________________________ Relationship _____________________________
Policy Holder's Employer ________________________ Insurance Company ______________________________
Group Number ______________________ Carrier ID # SS# ______________________________
Birthday of insured (if not self) ____________________

SECONDARY DENTAL INSURANCE INFORMATION (If applicable)

Policy Holder's Name ________________________________ Relationship ______________________________
Policy Holder's Employer _____________________________ Insurance Company _________________________
Group Number ______________________ Carrier ID # SS #____________________________
Birthday of insured (if not self) _______________________

MEDICAL INSURANCE INFORMATION (If applicable)

Policy Holder's Name ________________________________ Relationship _______________________________
Policy Holder's Employer _____________________________ Insurance Company _________________________
Group Number ______________________ Carrier ID # SS# ________________________________
Birthday of insured (if not self) ___________________________

I understand that payment is expected when services are rendered unless other arrangements are made in advance. I understand that due to the complex and ever-changing nature of medical and dental insurance policies, that it is not always possible to accurately predict or estimate what will be paid by insurance, therefore, I understand that I am responsible for whatever charges insurance does not cover. I also understand that it is the policy of Natural Dental Health Associates that if I need to cancel or change my appointment I must do so two business days prior to the appointment or I may be charged a $50 dollar failed appointment fee.

Signature ______________________________________ Date ________________

PATIENT REGISTRATION / MEDICAL HISTORY

All questions on this form must be answered to the best of your ability in order to receive treatment in this office. The questions asked relate directly to the safe and effective treatment you are to receive in this office. If you are unclear about a question or answer, or whether the question is relevant to your medical condition, please discuss the matter with the doctor. Some questions may not pertain to you or your medical condition: in that event please write "N/A" in the space provided. Please use blue or black non-erasable ink.

To properly evaluate your current health status, it may be necessary for the dentist to contact your physician. Included on this form is "Permission to Release Information." You are asked to sign it in the presence of a member of the office staff.

ALL INFORMATION YOU SUPPLY TO THE OFFICE ON THIS FORM, THE SUBSEQUENT INTERVIEW BY THE DENTIST, AND THAT RECEIVED FROM YOUR PHYSICIAN OR ANY OTHER SOURCE, WILL BE HELD IN THE STRICTEST CONFIDENCE AND WILL NOT BE DISCLOSED WITHOUT YOUR EXPRESS AND WRITTEN PERMISSION.

1) Physician contact information including address & telephone number: ______________________________________
____
2) Date of last visit to your doctor: _________________ If yes, describe: ____________________________________
3) Do you suffer from any disability? _______________ If yes, describe: ____________________________________
____
4) Are you taking any drugs or medication, including birth control pills? If yes, list and describe amounts and purpose. Note: There are drugs and medications used in routine dental care that may decrease the effectiveness of birth control pills.
____
____
5) Have you ever, or do you now take illegal drugs? If yes, what drugs and when were they taken? Note: there are drugs and medications used in routine dental care that are incompatible with several illegal drugs. The effect of the combination may be dangerous to your health and may be fatal. ____
____
6) Have you ever had an allergic reaction to medications, food, or other substances? If yes, list allergy and describe reaction:
____
6) Have you ever had a reaction to inexpensive jewelry or other metal against the skin? __________________________
7) Have you ever undergone material sensitivity or allergy testing / treatment? If so. When and by what type of practitioner?
____
8) Have you lost weight recently? If yes, describe: ____
9) Have you ever used Phenfen? If so when and how long ____
10) For women: Are you pregnant? If yes, when are you due? ____
11) Have you ever had or been treated for:

___ AIDS or HIV
___ Hepatitis A,B,C,D,E
___ Heart murmur or congenital heart disease
___ Heart attack, heart surgery, angina
___ Pacemaker, irregular beats, or other heart trouble
___ Asthma, TB, or other breathing problems
___ Hay fever
___ Renal dialysis or kidney problems
___ Tumor or other growths
___ Prosthetic joint replacements or organ transplant
___ Diabetes
___ Rheumatic fever or heart disease
___ Stomach or intestinal disease
___ Abnormal blood pressure
___ Excessive bleeding or anemia
___ Cancer, X-ray treatments, or chemotherapy
___ Venereal disease
___ Stroke, convulsions, or fainting spells
___ Arthritis or rheumatism

If yes, describe and provide current status: ____
____
____
____
____
____
____

MEDICAL/DENTAL HISTORY 2

12) Have you ever had a major operation? If yes, describe____

____

13) Have you ever had a serious injury to your head or neck? If yes, describe: ________________________________

14) Are you on a special diet? If yes, for what reasons and describe: ______________________________________

a) What supplements have you tried or are using now? ____
b) What types of sweeteners do you use? ____
c) What type of water do you drink? ____
d) Do you consume organic or standard food products? ____
e) Do you use tobacco? If yes, describe type and quantity: ____
f) Do you use caffeine? If yes, describe quantity: ____

15) Have you consulted or been treated by a psychiatrist, psychologist, or counselor? If yes, describe: _____________

____

15) Are there any other problems about your health that you are aware of? ________________________________

____

16) Date of your last visit to a dentist ____

17) Reason for your last visit (or series of visits) ____

18) Do you require or prefer nitrous oxide at your dental appointments? ___________________________________

19) Do you have any of your X-rays or dental records? ____

20) In respect to any previous dental treatments, have you ever experienced

___ fainting ___ allergic reaction ___ abnormal bleeding

21) Do your gums bleed on brushing or eating? ____

22) Does food catch between your teeth? ____

23) Have your teeth shifted? Are there spaces between your teeth now where there were not before? Are your teeth flaring or have some of your teeth become loose? ____

____

24) Are any of your teeth sensitive to heat, cold, or pressure? ____

25) Do any of your teeth ache? ____

26) Do you grind your teeth or clench your jaws? ____

27) Do your jaw muscles ever ache or become sore? ____

28) Do you experience any problems on opening your jaws when speaking, eating, or yawning? __________________

____

29) Do you experience any problems when opening your jaws as far as you can? ______________________________

30) Have you ever had an injury to your jaw? If yes, describe: ____

NOTE: A change in your health status should be reported to the office at the earliest possible time.
Permission to Release health Information

- All the information recorded above is accurate to the best of my knowledge.
- I grant the right to the dentist to release health information, X-rays, and information about my dental treatment to my insurance company, and/or other health practitioners.
- I hereby authorize my insurance benefits to be paid directly to the dentist.

Patient Signature ______________________________________ Date __________________

Print Name ______________________________________ Witnessed by office staff ________

If other than patient, indicate relationship ____

Dentist's History Review & Significant Findings

Dr. Signature ____