NEW PATIENT INFORMATION FORM

PATIENT NAME:_____ Date of Birth:_____

Address:_____ Social Security Number:_____
Driver's License Number:_____
_____ E-Mail Address:_____
Home Phone:_____
Place of Employment:_____ Work Phone:_____
Cell Phone: _____
Work Address:_____ Best Time to Contact You:_____

**If patient is under 18 years age: Name of Primary Guardian: _____
Best Contact Phone Number: _____

DENTAL INSURANCE

Primary Dental Insurance Company:_____
Claims Address:_____
_____
Insured:_____ SSN#_____Group#_____Date of Birth_____
Place of Employment for the Primary Dental Coverage: _____

Secondary Dental Insurance Company:_____
Claims Address:_____
_____
Insured:_____ SSN#_____Group#_____Date of Birth_____
Place of Employment for the Secondary Dental Coverage: _____

DENTAL HISTORY

What is the primary reason for your visit today?_____

Do you have any of the following?

	Yes	No		Yes	No		Yes	No
Painful Gums			Grinding/Clenching			Growth in Mouth		
Swollen Gums			Lip/Cheek Biting			Difficult Jaw Opening		
Bleeding Gums			Nail/Pen Biting			Difficult Jaw Closing		
Loose Teeth			Mouth Breathing			Gag Easily		
Sensitive Teeth			Mouth Sores			Other		
Other:								

Last Dental Visit_____ Last Cleaning_____ Last X-rays_____

How did you hear about Bellefonte Family Dentistry?

☐ Newspaper ☐ TV ☐ Yellow Pages ☐ Radio ☐ Mail

Other: _____

PLEASE TURN PAGE OVER TO COMPLETE HEALTH QUESTIONS

MEDICAL HISTORY

Name of Physician:_____ Phone Number:_____
Are you under the care of a physician now?_____
Have you ever been hospitalized or had a major operation in the last five years?
Discuss_____
Are you allergic to any medications or substances? Please check appropriate boxes below:

☐Aspirin ☐Penicillin ☐Codeine ☐Acrylic ☐Metal ☐Latex Rubber
Other_____

MEDICATIONS

Prescriptions	Over-the-Counter

Do you now have or have you ever had any of the following? Please check {x} appropriate boxes.

	Yes	No		Yes	No		Yes	No
Glaucoma			Rheumatic Fever			Liver Disease		
Heart Murmur			Scarlet Fever			Hepatitis A/B/C		
Irregular Heart Beat			Heart Pacemaker			Psychiatric Treatment		
Angina/Chest Pain			High Blood Pressure			Epilepsy/Seizures		
Heart Attack/Failure/Surgery			Joint Replacement			HIV (AIDS)		
Congenital Heart Disorder			Asthma			Kidney Disease		
Mitral Valve Prolapse			Tuberculosis			Diabetes		
Artificial Heart Valves			Stroke			A1C1 Value		
Other:								

Women: (Please Check) ☐Pregnant/trying to get pregnant ☐Nursing ☐Taking Contraceptives

Have you ever taken premedication before dental appointments? _____

Who should we contact in case of emergency? _____Phone:_____

I am aware of the office policy regarding PRIVACY PRACTICES and have had the opportunity to review this policy and receive a copy if I desire. By my signature below I allow the dentist to discuss my conditions with my physician and request any necessary medical information from him/her. I authorize the dentist to release information about my dental treatment to other health professionals and to insurance companies when needed. I certify that I can read and understand English; the above questions were answered completely without any purposeful false statements.

X_____ _____
Patient Signature (Parent or Guardian) Date