New Leaf Dental

We Choose To Charge Less-
So You Can Smile More

ABOUT YOU

Date: ___/___/_____

Name:_____

I prefer to be called:_____

Birthdate:___/___/____ Social Sec #_____

Gender:_____ Marital Status:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Home #(___)_____ Cell #(___)_____

Work #(___)_____ DL:_____

E-Mail:_____

Employer:_____

How Long There:_____ Occupation:_____

Where & When are the best times to reach you?:_____

_____

Other family members being seen by us:_____

_____

Previous/Current Dentist:_____

Last visit date:_____

SPOUSE INFORMATION

Name:_____

Employer:_____

Cell # (___)_____ Work # (___)_____

Birthdate:___/___/_____ Social Sec #_____

Person Responsible for Account:_____

INSURANCE INFORMATION

Primary Insurance:

Name of Insured:_____

Relation to Patient:__Self __Spouse __Child __Other

Insured Social Sec #_____

Birthdate: ___/___/_____ Employer_____

Insurance Company_____

Member ID #:_____ Group #_____

Secondary Insurance:

Name of Insured:_____

Relation to Patient:__Self __Spouse __Child __Other

Insured Social Sec #_____

Birthdate:___/___/_____ Employer_____

Insurance Company_____

Member ID #:_____ Group #_____

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.

I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

_____

Signature **Date**

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

Turn Over for Health History----->

MEDICAL HISTORY

Medical Doctor:_____

Office Phone #_____ Last Exam:__/__/____

Your current physical health is: __Good __Fair __Poor

Are you currently under the care of a physician: __No __Yes

Are you taking any prescription/ over-the-counter drugs/ herbs or vitamins?: __No __Yes
Please list each one:_____
_____

Or Do you have a medication list? __Yes __No

Are you Allergic to any of the following drugs?:

☐ Local Anesthetics	☐ Penicillin
☐ Aspirin	☐ Erythromycin
☐ Amoxicillin	☐ Latex
☐ Codeine	☐ Sulfa Drugs
☐ Iodine	☐ Mint
☐ Other _____	

_____
_____
_____
_____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

☐ High Blood Pressure	☐ Leukemia
☐ Low Blood Pressure	☐ Cancer
☐ Rheumatic Fever	☐ Angina
☐ Heart Murmur/Valve	☐ Asthma
☐ Fainting/ Seizures	☐ Heart Disease
☐ Respiratory Problems	☐ Arthritis
☐ Epilepsy/Convulsions	☐ HIV/AIDS
☐ Kidney Diseases	☐ Stroke
☐ Hepatitis/Jaundice	☐ Glaucoma
☐ Thyroid Problem	☐ Heart Attack
☐ Hay Fever/Allergies	☐ Liver Disease
☐ Cardiac Pacemaker	☐ Tuberculosis
☐ Joint Replacement	☐ Diabetes
☐ Stomach Troubles/Ulcers	
☐ Blood thinner_____	

FOR WOMEN:
Are you taking Birth Controls Pills?: __No __Yes
Are you pregnant or Think you may be?:__No __Yes
Are you nursing?: __No __yes

DENTAL HISTORY

Why have you come to the dentist today?:_____
_____

Are you currently in pain?: ___No ___Yes

Have you ever had a serious/difficult problem associated with any previous dental work?:__No __Yes

Do you now or have you ever experience pain or discomfort in your jaw joint (TMJ/TMD)? __No __Yes

Your current dental health is: __Good __ Fair __Poor

Do you like the appearance of your smile?:__No __Yes

If you could change anything about it, what would it be?:_____

Do your gums ever bleed?: ___No ___Yes

Have you ever had instruction on the correct method of brushing your teeth? ___No ___Yes

Have you ever had instructions on the care of your gums? ___No ___Yes
How many times a day do you brush?:_____
How Many times a week do you floss?:_____

Do you have frequent headaches? ___No ___Yes

Have you ever seen a dental specialist (Endodontist, Periodontist, Etc)? ___No ___Yes
Have you had any orthodontic work? ___No ___Yes

Do you clench or grind your teeth? ___No ___Yes

In the event of an emergency, is there someone we should contact?

Name:_____ Relation:_____
Home #:_____ Cell #:_____

How Did you hear about our office?

__ Insurance plan/provider __Other Doctor
__ Social Media __ Coupon/Giveaway
__ Google/Website __ Yellow Pages
__ Friend/Family Referral __Other_____
Referral's Name:_____

_____

Signature **Date**