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?:

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

_____
_____
_____
_____

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

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