



# WELCOME TO DOWNTOWN DENTAL ASSOCIATES

We are complimented that you have selected us to provide dental care for you and your family. So that we can serve you better, please complete both sides of this new patient history form.

## PATIENT INFORMATION

Patient's Name \_\_\_\_\_ Today's Date \_\_\_\_\_

How Do You Wish To Be Addressed? \_\_\_\_\_ E-mail \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_

If patient is a minor, give parent's or guardian's name \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

## RESPONSIBLE PARTY / BILLING INFORMATION

Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address (if different than above) \_\_\_\_\_

How long at this address? \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext \_\_\_\_\_

Previous Address (if less than 3 years) \_\_\_\_\_ How long at this address? \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ SS # \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_ Work Phone \_\_\_\_\_

## INSURANCE INFORMATION

Insured's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Insured's SS # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Do you have dual coverage?  Yes  No If Yes: \_\_\_\_\_

Insured's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Insured's SS # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Insured's Employer \_\_\_\_\_

## CONSENT FOR DENTAL TREATMENT

I hereby authorize Downtown Dental Associates to take dental X-rays and to perform dental procedures as may be deemed necessary or advisable in the diagnosis and treatment of my dental condition. I understand that any dental treatment involves certain risks. If I wish a more detailed explanation of diagnosis, treatment risks, and alternatives to treatment, I will ask for such.

Date \_\_\_\_\_ Patient Signature (or parent for minor) \_\_\_\_\_

After initial X-rays and examination, we will give you an estimate of fees to cover your treatment. At that time, financial arrangements will be made before treatment is rendered.

Preferred method of payment \_\_\_\_\_ Cash \_\_\_\_\_ Check \_\_\_\_\_ Bankcard

## DENTAL HISTORY

What are your present dental concerns? \_\_\_\_\_  
When did you last see a dentist? \_\_\_\_\_ When did you last have dental X-rays? \_\_\_\_\_  
Have you avoided regular dental care? \_\_\_\_ yes \_\_\_\_ no Why? \_\_\_\_\_  
Do you feel you have active decay? \_\_\_\_ yes \_\_\_\_ no  
Have you ever had any periodontal (gum) treatments? \_\_\_\_ yes \_\_\_\_ no  
How often do you brush? \_\_\_\_\_ Floss? \_\_\_\_\_ Use other cleaning aids? \_\_\_\_\_  
Are you happy with the appearance of your teeth? \_\_\_\_ yes \_\_\_\_ no Would you like your teeth to be whiter? \_\_\_\_ yes \_\_\_\_ no  
What are your dental expectations? \_\_\_\_\_  
Do you currently have problems with any of the following? (please circle those that apply)

Bleeding Gums	Pain When Chewing	Frequent Tooth or Filling Breaks
Bad Breath	Jaw Clicking or Popping	Teeth Sensitive to Pressure
Unpleasant Taste	Headaches or Neck Pain	Hot or Cold Tooth Sensitivity
Loose or Chipped Teeth	Grinding or Clenching of Teeth	Sweet Sensitive Teeth
Missing Teeth	Sore Areas in the Mouth	Other

Previous Dentist \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Would you like us to request your records from your previous dentist? \_\_\_\_ yes \_\_\_\_ no Date of last dental cleaning \_\_\_\_\_  
My previous dental experience has been \_\_\_\_\_ positive \_\_\_\_\_ neutral \_\_\_\_\_ negative

## MEDICAL HISTORY

Physician's Name \_\_\_\_\_ Phone # \_\_\_\_\_  
How would you describe your health? \_\_\_\_\_ Date of last Physical \_\_\_\_\_  
Have you been hospitalized in the last 2 years? \_\_\_\_\_ For? \_\_\_\_\_  
Please list all medications and drugs you are taking \_\_\_\_\_

Have you ever had an adverse reaction or allergies to any medications or substance? (Please circle if allergic)

Aspirin	Valium	Sulfa Drugs	Penicillin	Novacaine	Nitrous Oxide	Latex
Codeine	Iodine	Tetracycline	Erythromycin	Xylocaine	Other	

Have you ever had any of the following: (please circle all that apply)

Heart Trouble	Dizziness or Fainting	Hepatitis (Type _____)	HIV - AIDS - ARC
High/Low Blood Pressure	Diabetes	Cancer	Venereal Disease
Heart Attack or Stroke	Kidney or Liver Disease	Tumor or Growth	Cold Sores
Heart Murmur	Ulcers or G.I. Problems	X-ray/Chemotherapy	Fever Blisters
Rheumatic Fever	Thyroid Problems	Arthritis or Gout	Herpes
Congenital Heart Problems	Asthma or Allergies	Jaw Joint Pain	Bruise Easily
Heart Valve or Pacemaker	Sinus Problems	Glaucoma	Frequent Thirst
Bleeding Problem or Anemia	Emphysema	Epilepsy or Seizures	Frequent Urination
Blood Disease	Lung Disease	Hypoglycemia	Use Tobacco
Blood Transfusion	Tuberculosis	Drug/Alcohol Addiction	Now Pregnant
Artificial Joint	Psychiatric Care	Eating Disorder	

Do you have any condition or problem not listed above which we should know about? Please explain \_\_\_\_\_

Med. Update / /	Update / /	Update / /	Update / /
Changes: _____	Changes: _____	Changes: _____	Changes: _____
_____	_____	_____	_____
_____	_____	_____	_____

## EMERGENCY INFORMATION

Name of nearest relative not living with you \_\_\_\_\_  
Complete Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_