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New Patient Form

Date: _____ Name: _____ I prefer to be called: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ I prefer to be contacted via: home ph. Cell email text

Date of Birth _____ Male Female Who may we thank for referring you? _____

Check appropriate Box Minor Single Married Divorced Separated Widowed

Person to contact in case of emergency: _____ Phone: _____

Responsible Party

Name: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ ZIP: _____

Assign Insurance Benefits to Dr. Indah (Y) (N) Signed _____ Date: _____

Insurance Information

Name of Insured _____ Date Of Birth _____ Relationship to Patient _____

SSN# _____ Employer _____ Work Phone: _____

1) Insurance Company _____ Group # _____ ID# _____

Insurance Phone # _____

2) Insurance Company _____ Group # _____ ID# _____

Insurance Phone # _____

Patient Dental Health

Why have you come in to see us today? (e.g. Pain, checkup, etc.)

Previous Dentist: _____ Last Visit _____ Date of Last Cleaning _____

Reason for changing dentists: _____

Problems with past dental treatment: _____

Are you nervous about seeing a dentist? (Y) (N) If yes, why: _____

How often do you brush? _____ Do You Floss? (Y) (N) How Often? _____

Do you Pre-medicate for dental treatment? (Antibiotics) (Y) (N)

What are your dental priorities? (e.g. dental health, problem focus, etc.) _____

Patient Medical History

I consider my health to be (please check one) Excellent Good Fair Poor

Do you have any of the following (please circle Y for yes and N for no)

- | | | |
|--|--|---|
| Y N Heart Disease | Y N Liver Disease | Y N Heart Murmur/Mitral Valve Prolapse |
| Y N Jaundice | Y N Stroke | Y N Hepatitis Type: ____ |
| Y N Congenital Heart Lesions | Y N Diabetes | Y N Rheumatic Fever |
| Y N Excessive Urination and/or thirst | Y N Abnormal Blood Pressure | Y N Infectious Mononucleosis (Mono) |
| Y N Anemia | Y N Herpes | Y N Prolonged Bleeding Disorder |
| Y N Arthritis | Y N AIDS | Y N Immune Suppressed Disorder |
| Y N Tuberculosis or Lung Disease | Y N Hearing Loss | Y N Sexually Transmitted Disease |
| Y N Asthma | Y N Kidney Disease | Y N Hay fever |
| Y N Tumor or Malignancy | Y N Fainting Spells | Y N Glaucoma |
| Y N Sinus Trouble | Y N Cancer/Chemotherapy | Y N Epilepsy/Seizures |
| Y N Radiation Treatment | Y N History of Emotional or Nervous disorder | |
| Y N Ulcers | Y N History of Drug Addiction | Y N Implants/Artificial Joints: Hip, Knee, etc. |
| Y N I smoke or use tobacco. If yes, how much per day? ____ How many years? _____ | | |
| Y N I have consumed alcohol within the last 24 hours. | | |
| Y N Take oral Bisphosphonate? (Fosamax/Actonel/Boniva) | | Y N Take IV Bisphosphonate? |
- Women:** Are you taking Birth control medication? **Y N** Are you /could you be pregnant or nursing? **Y N**
 Y N Do you have any other medical problem or medical history **Not listed on this form?** _____

Are you allergic to any of the following?

- Y N Aspirin Y N Ibuprofen
- Y N Sulfa/Sulfites/Sulfides
- Y N Penicillin Y N Other _____
- Y N Codiene/bicodin/Valium
- Y N Local Anesthetics (Novocaine)
- Y N Latex Y N Plastics Y N Metals

Please List all Medications you are currently taking:

_____ for _____

_____ for _____

_____ for _____

_____ for _____

_____ for _____

Physician's Name _____ Phone #: _____ Patient Initials: _____ Date: _____

Patient Medical History – Continued

Please circle Y for yes or N for no

Y N I clench or grind my teeth during the day or while sleeping.

Y N Jaw or joint pain.

Y N My gums bleed while brushing or flossing.

Y N My gums feel tender or swollen.

Y N I like my smile.

Y N I have problems eating.

Y N I prefer tooth colored fillings.

Y N I have had orthodontics.

Y N I avoid brushing part of my mouth due to pain.

Y N I have had a facial or jaw injury.

Y N I want my teeth whiter.

Y N Do you have frequent or regular headaches? Upon awakening/late afternoon

Y N Are your Jaw muscles sore or tender?

Y N Are your joints sore or tender when you eat or chew?

Y N Do your joints lock when you are trying to open or close?

Y N Have you ever received an injury to your jaw or face? If yes, Describe:

Y N Do your joints make any noise such as snapping, clicking, or popping?

Y N Do you have any teeth that are sensitive, sore, aching, or uncomfortable?

Y N Have you ever worn a splint or night guard? If yes, how many: _____ How long ago? _____

Y N Are you taking or have you taken any medication for these symptoms? If yes, describe:

Y N Have you ever seen a dentist or a TMJ specialist for treatment of any of the above symptoms? If yes, how long ago? _____

History Updates/Notes: _____

Patient Initials: _____ Date: _____