Inland Dental Group

NEW PATIENT FORM

Thank you for selecting our dental office. To help us meet all of your health care needs, please complete this form as accurately as possible

PATIENT INFORATION

Name _____ Birth Date _____ Social Security # _____
Address _____ City _____ State _____ Zip Code _____
Sex ☐ ☐F ☐arried ☐ngle ☐vorced ☐parated ☐inor
E-mail _____ Home Phone (____)_____Cell Phone(____)_____
Employer Name _____ Employer Phone (____)_____
Spouse or Parent's Name _____ Work Phone (____)_____Cell Phone(____)_____
Person to contact in case of emergency _____ Phone (____)_____
Whom may we thank for referring you? _____

RESPONSIBLE PARTY

Name responsible party _____ Relationship to patient _____
Social Security # _____ Birth Date _____ Phone (____)_____
Employer _____ Work Phone (____)_____

INSURANCE INFORMATION

Subscriber Name _____ Relationship to patient _____
Birth Date _____ Social Security # _____ Date Employed_____
Insurance Name _____ Insurance ID # _____ Group ID # _____
Secondary Insurance (if applicable)
Subscriber Name _____ Relationship to patient _____
Birth Date _____ Social Security # _____ Date Employed_____
Insurance Name _____ Insurance ID # _____ Group ID # _____

NOTICES

Please Initial Below:
_____ I Have received a copy of Inland Dental Group's Materials Fact Sheet.
_____ I assign Inland Dental Group my right, title, and interest in and to any and all dental benefits otherwise payable to me for oral health treatment rendered by the assignee. I acknowledge that billing my insurance company for the services rendered is a courtesy done by Inland Dental Group. I am still responsible for paying above referenced dentist to the extent the relevant insurer or payer does not pay the dentist in full.

DENTAL HISTORY

Reason for today's visit _____Date of last Dental visit _____
Last Dental Cleaning _____ Date of last dental x-rays _____
How often do you have dental examinations? _____

Check all of the following that apply to you.

☐ad Breath ☐rinding Teeth ☐ail Biting ☐encil Biting
☐leeding Gums ☐obacco Use ☐louth Breathing ☐humb Sucking
☐ensitivity hot/cold ☐ensitivity to sweets ☐w popping/clicking ☐ry Mouth

How often do you floss? _____ How often do you brush? _____

*Circle **YES** or **NO***

YES/NO Experiencing dental issues today
YES/NO Interested in whiter teeth
YES/NO Are you experiencing Discomfort
YES/NO Do you have any missing teeth

Have you ever

YES/NO Been in an accident causing damage to your teeth
YES/NO Experienced loose teeth or changes in bite
YES/NO Received periodontal (Gum) Treatment
YES/NO Had Orthodontic Treatment

Denture/Partial wearing patients

YES/NO Do you wear a denture or partial
YES/NO Does your denture cause irritation/soreness
YES/NO Are your dentures loose
YES/NO How old is your denture? _____

How would you rate your smile on a scale from 1 to 10, with 10 being the Highest? _____
_____
Are you interested in: Orthodontic treatment? **YES/NO** Cosmetic treatment? **YES/NO**
Do you feel nervous about dental treatment? **YES/NO**
If so, Explain _____ _____
Is there anything else about having dental treatment that you would like for us to know? _____
_____

CONFIDENTIAL HEALTH HISTORY

CIRCLE THE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

Inland Dental Group

YES/NO Is your general heath good? If no, explain: _____

YES/NO Have you gone to the hospital, emergency room or had a serious illness in the last three years? If yes, explain: _____

_____

YES/NO Are you being treated by a physician now? If yes, explain: _____

YES/NO Have you had problems with prior dental treatment? If yes, explain: _____

YES/NO Have you had any recent surgeries? If yes, explain: _____

YES/NO Are you in pain now? If yes, explain: _____

YES/NO Have you ever been pre-medicated for dental treatment? If yes, explain: _____

ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING?

YES/NO Alcohol **YES/NO** Antibiotics **YES/NO** Aspirin **YES/NO** Bisphosphonate (fosamax/actonel)
YES/NO Over the counter medication **YES/NO** Recreational drugs **YES/NO** Supplements **YES/NO** Tobacco (in any form)
YES/NO Blood thinners of any type
YES/NO Have you ever taken Phen Phen? If yes, when? _____
OTHER (Please List): _____

FOR WOMEN ONLY

YES/NO Are you or could you be pregnant? If yes, how far along? _____
YES/NO Are you nursing? **YES/NO** Are you taking birth control?

ARE YOU EXPERIENCING ANY OF THE FOLLOWING?

YES/NO Bleeding problems	**YES/NO** Dizziness	**YES/NO** Headaches	**YES/NO** Shortness of breath
YES/NO Blurred vision	**YES/NO** Dry Mouth	**YES/NO** Joint pain or stiffness	**YES/NO** Swollen Ankles
YES/NO Bruise Easily	**YES/NO** Excessive Thirst	**YES/NO** Persistent cough	
YES/NO Chest Pain (angina)	**YES/NO** Fainting spells	**YES/NO** Recent significant weight loss	
YES/NO Difficulty swallowing	**YES/NO** Fever	**YES/NO** Sinus problems	

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

YES/NO AIDS/HIV	**YES/NO** Diabetes	**YES/NO** Herpes	**YES/NO** Skin Disease
YES/NO Anemia	**YES/NO** Eating disorders	**YES/NO** High blood pressure	**YES/NO** Stroke
YES/NO Artificial Joints	**YES/NO** Emphysema or lung disease	**YES/NO** Kidney or bladder disease	**YES/NO** Stomach problems
YES/NO Arthritis, Rheumatism	**YES/NO** Eye Disease	**YES/NO** Liver Disease	**YES/NO** Thyroid Disease
YES/NO Asthma	**YES/NO** Hardening of arteries	**YES/NO** Osteoporosis	**YES/NO** Transplants
YES/NO Cancer	**YES/NO** Heart Attack	**YES/NO** Psychiatric care	**YES/NO** Tuberculosis
YES/NO Canker or cold sores	**YES/NO** Heart Disease	**YES/NO** Rheumatic fever	**YES/NO** Tumors
YES/NO Chemotherapy	**YES/NO** Heart murmurs	**YES/NO** Seizures	**YES/NO** Ulcers
YES/NO Cosmetic surgery	**YES/NO** Hepatitis	**YES/NO** Sexually transmitted disease	

List any other major illnesses not listed above. _____

ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING?

YES/NO Asprin	**YES/NO** Erythromycin	**YES/NO** Nitrous Oxide	**YES/NO** Tetracycline
YES/NO Codine	**YES/NO** Latex	**YES/NO** Penicillin	**YES/NO** Valium
YES/NO Darvon	**YES/NO** Local anesthetics (Lidocaine)	**YES/NO** Percodan	**YES/NO** Vicodin
YES/NO Demerol	**YES/NO** Metal	**YES/NO** Sulfa	**YES/NO** Iodine

YES/NO OTHER _____

IS THERE ANY ISSUE OR CONDITION THAT YOU WOULD LIKE TO DISCUSS WITH THE DENTIST IN PRIVATE? **YES/NO**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potential medically compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's signature _____ Date _____

Physician's Name _____ Physician's Phone Number (____)_____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes in my health and or medication. I will not hold my dentist or any other member of my dentist's staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient (Parent/Guardian) _____ Date _____

Signature of Dentist _____ Date _____