Maple Family DENTAL

NEW PATIENT INFO

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

Name: _____
Last First MI (Preferred)

Birthdate: _____ SS #: _____ Gender: ___M ___F ___Other

Best phone number to reach you: _____ Married: ___ Y ___ N

Email: _____

Address: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Occupation/Employer: _____

How did you hear about us?

_____

Please list family members seen by us: _____

Why did you come to the dentist today?

___ Check up/Cleaning ___ Broken teeth/dental work ___ Pain ___ Cosmetics

How long since your last dental visit? _____

Have you ever had a serious / difficult problem associated with any previous dental work? ___ Yes ___ No

Do you now or have you ever experienced pain/discomfort in you jaw joint (TMJ/TMD)? ___ Yes ___ No

Your current dental health is: ___ Good ___ Fair ___ Poor

Do you like your smile? ___ Yes ___ No

Do your gums ever bleed? ___ Yes ___ No

How many times a week do you floss or waterpick? ___ 3 or less ___ 4-6 ___ 7 or more

How many times a day do you brush? ___ 0 ___ 1 ___ 2 or more

Type of bristles: ___ Hard ___ Medium ___ Soft

MEDICAL HISTORY

Emergency Contact: _____ Phone: _____ Relationship: _____

List all medications that you are now taking:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Are you allergic to any of the following?

Y	N		Y	N	
___	___	Anesthetic	___	___	Erythromycin
___	___	Aspirin	___	___	Latex
___	___	Codeine	___	___	Penicillin
___	___	Ibuprofen	___	___	Tetracycline

Other allergies not listed above:

_____

Have you ever had any of the following medical problems?

Y	N		Y	N	
___	___	Asthma	___	___	Kidney Disease
___	___	Bleeding Problems / Hemophilia	___	___	Liver Disease
___	___	Cancer / Chemotherapy	___	___	Hepatitis
___	___	Diabetes	___	___	Psychiatric Treatment
___	___	Anemia	___	___	Rheumatic Fever
___	___	Congenital Heart Defect	___	___	Sinus Trouble
___	___	High Blood Pressure	___	___	Stroke
___	___	Joint Replacement	___	___	Ulcers
___	___	Herpes/fever blisters	___	___	Seizures / Epilepsy
___	___	Radiation Treatment	___	___	Fainting Spells
___	___	Emphysema	___	___	Respiratory Problems / Difficulty Breathing
___	___	Heart Attack	___	___	Tuberculosis
___	___	HIV / Aids	___	___	Alcohol / Drug Abuse
___	___	Pacemaker / Defibrillator	___	___	Sickle Cell Disease/Traits
___	___	Thyroid Problems	___	___	Artificial Heart Valve

Other conditions not listed above:

For women -- please select if you are:

Pregnant: ___ Yes ___ No If pregnant, number of weeks: _____

Nursing: ___ Yes ___ No Taking birth control pills ___ Yes ___ No

Do you require antibiotics before dental treatment? ___Yes ___ No

Have you ever taken Fosamax or any Bisphosphonate (medication for Osteoporosis)? ___ Yes ___ No

If yes to the above, when? _____

Your current physical health is: ___Good ___ Fair ___ Poor

Tobacco use? If so, what kind and how much? ___Yes ___No _____

Unusual reaction to dental injections? _____

By signing below, I confirm 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.

Patient/Guardian Signature:

Today's Date: _____

BASIC CONSENT FOR FIRST VISIT

I consent to having the following done: X-rays, Exam, Cleaning. CHECK HERE: ___

I understand that holding my mouth open during treatment may temporarily leave my jaw feeling stiff and sore and may make it difficult for me to open wide for several days. I must notify your office if this or other concerns arise. I understand that if the recommended treatment is not performed, tooth or gum damage may progress causing me to lose one or more of my teeth. I may also experience symptoms that may be damaging to my overall health and which may increase in severity, and the cosmetic appearance of my teeth may deteriorate. I understand that every reasonable effort will be made to ensure the success of my treatment. I understand that each person and situation is unique, and no guarantee or assurance has been given to me by anyone that the proposed treatment will cure or improve my condition(s).

CHECK HERE: ___

I understand that antibiotics, anesthetics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. I understand that all medications have the potential for accompanying risks, side effects, and drug interactions. Therefore it is critical that I tell my dentist of all medications I am currently taking, which I have done.

CHECK HERE: ___

I understand that I may have loss of feeling in my teeth, lips, tongue and surrounding tissue (paresthesia) following injections for local anesthesia with any procedure. Rarely, temporary or permanent nerve injury and loss of feeling may result from an injection.

CHECK HERE: ___

SIGN HERE: 

TODAY'S DATE: _____

OFFICE USE ONLY
Confirmation of review of medical / dental information above with the patient named herein, and attestation of discussion of the risks, benefits, consequences, and alternatives of proposed treatment. Patient will be given the opportunity to ask questions, and I will ensure the patient understands what has been explained.

Maple Family DENTAL

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

THIS GIVES US PERMISSION TO SHARE INFORMATION WITH YOUR INSURANCE OR SPECIALISTS, WHEN RELEVANT TO YOUR CARE.

(YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT.)

I HAVE BEEN OFFERED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

SIGN HERE:

TODAY'S DATE: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowedgement of receipt of our Notice of Privacy Practices, as required by law.