Today's Date: _____

NEW PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If you have any questions, do not hesitate to ask.

Patient Name: _____ Preferred Name: _____

Date of birth: _____ Social Security Number: _____Sex: _____ Age:_____

Single _____ Married____ Dependent_____ Widowed_____

Mailing Address: _____ City:_____ State: _____ Zip: _____

Home Phone:_____ Cell Phone:_____

Work Phone: _____ Email: _____

Employer/Occupation:_____ Employer Address: _____

Spouse's Name: _____ Spouse's Phone: _____

Emergency Contact Name: _____ Phone Number: _____

Primary dental insurance: _____ Group #:_____

Subscriber's Name:_____ Date of birth: _____ SS#:_____

Secondary dental insurance: _____ Group #:_____

Subscriber's Name:_____ Date of birth: _____ SS#:_____

Name of your medical doctor: _____ Are you under the care of a physician now? _____

If so, for what reason? _____

Please list daily medications:_____

MEDICAL HEALTH HISTORY

Have you ever had the following? (Please circle yes or no)

Allergies to latex	YES	NO	Heart Murmurs	YES	NO
Allergies to penicillin	YES	NO	High Blood Pressure	YES	NO

Continued on back

Allergies to other medicines	YES	NO	HIV (AIDS)	YES	NO
Please list below:			Hepatitis	YES	NO
_____			Implants (joint, heart, valves, etc)	YES	NO
Asthma	YES	NO	Cancer	YES	NO
Diabetes	YES	NO	Stroke	YES	NO
Epilepsy	YES	NO	Tendency to bleed	YES	NO
Heart Disease	YES	NO	Tuberculosis	YES	NO
Premedication required by physician	YES	NO	Are you pregnant?	YES	NO

If yes, please explain: _____

_____

DENTAL HEALTH HISTORY

Are you apprehensive about dental treatment?	YES	NO	Do you have any pain associated with teeth?	YES	NO
Are you dissatisfied with appearance of your teeth?	YES	NO	Are you interested in teeth whitening?	YES	NO
Do you clench or grind your jaws frequently?	YES	NO	Do you experience pain in your jaw?	YES	NO
Do you use any tobacco products?	YES	NO	Are you interested in straightening your teeth?	YES	NO

Name of previous dentist: _____ Date of last visit: _____

How did you hear about Greenway Dental Care? _____

I understand the information I have given today is correct to the best of my knowledge. I understand this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical/dental status. I also understand that I am responsible for payment of services rendered, and for paying any co-payment and deductible that my insurance does not cover.

Signature: _____ Date:_____