NEW PATIENT FORM

Date: _____

Patient Name: _____ (First, Middle, Last)

Birthdate: ___ (day)/ ___ (month)/ _____ (year) M Male F Female

Address:
_____

City: _____ Province: _____ Postal Code: _____

Home Phone #: (____)_____ Cell Phone #: (____)_____

Work Phone #: (____)_____

E-mail Address:
_____

Parent/Guardian (if under18 yrs old): _____

Parent/ Guardian Phone # (if different from above): (____)_____

Are any of your family members (spouse/children/parent, etc) already patients of our office? If so, and you are covered under the same dental insurance plan, please list their name (so we can add you to their file):

_____
_____

Health Card #: _____ Treaty # (if applicable): _____

Do You have Dental Insurance? _____ Insurance Company Name: _____

Insured's Name (if not yourself): _____
(First, Last)

Insured's Birthdate (if not yourself): ____ (day)/ ____ (month)/ _____ (year)

Relationship to Insured (if not yourself): _____(spouse, common law, child, etc.)

Group (Plan, Policy or Local)#: _____ Certificate or ID #: _____

Insured's Employer:
_____

Secondary Insurance : (please inform receptionist if you have secondary insurance)

How did you hear about Rosemont Dental Clinic? _____

What is the main purpose of today's visit? _____

CONTINUE OTHER SIDE

Are you currently in pain? YES / NO
Do you require antibiotics before dental treatment? YES / NO
Have you experienced problems associated with any previous dental work? YES / NO
If yes, explain:
_____
Have you ever experienced any discomfort in your jaw joint (TMJ/ TMD)? YES / NO
Do you grind your teeth at night? YES / NO
Do you snore at night? YES / NO
Last dental visit?
_____

MEDICAL HISTORY

Do you have a personal physician? YES / NO Physician's name:_____
Physician's phone #:_____
Are you currently under the care of a physician? YES / NO
If yes, explain:
_____
Do you smoke or use tobacco in any other form? YES / NO
Do you have any drug or material allergies? YES / NO
If yes, please list:
_____
For Women: Are you pregnant? YES / NO / UNSURE How many weeks? ___
Are you nursing? YES / NO

Do you or have you experienced any of the following? Please list year beside each.

Y N Abnormal bleeding	Y N Alcohol abuse	Y N Anemia
Y N Arthritis	Y N Artificial bones/joints	Y N Artificial valves
Y N Asthma	Y N Blood transfusion	Y N Cancer
Y N Colitis	Y N Cong. Heart defect	Y N Diabetes
Y N Difficulty breathing	Y N Drug abuse	Y N Emphysema
Y N Epilepsy	Y N Fainting spells	Y N Fever blisters
Y N Glaucoma	Y N Osteoporosis	Y N Headaches
Y N Heart attack	Y N Heart Murmur	Y N Heart Surgery
Y N Hemophilia	Y N Hepatitis B	Y N Hepatitis C
Y N Cold Sores	Y N HIV + / AIDS	Y N Kidney Problems
Y N Liver disease	Y N Low blood pressure	Y N Lupus
Y N Mitral valve prolapsed	Y N Pacemaker	Y N Persistent cough
Y N Psychiatric problems	Y N Chemotherapy	Y N Radiation treatment
Y N Rheumatic fever	Y N Scarlet fever	Y N Seizures
Y N Shingles	Y N Sickle cell disease	Y N Sinus problems

Y	N	Stroke	Y	N	Thyroid problems	Y	N	Tonsilitis
Y	N	Tuberculosis	Y	N	Ulcers	Y	N	High blood pressure
Y	N	Fibromyalgia						

Please list any serious medical conditions you have (or have experienced) as well as the year:_____
_____
_____

Please list ALL medications you are currently taking:
_____
_____
_____

AUTHORIZATIONS

I affirm that the information I have given is correct to the best of my knowledge. It is my responsibility to inform the office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.
I certify that I am covered by _____Insurance Co. and I assign directly to Dr. Jun / Rosemont Dental Clinic all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits.

_____

Signature Date