New Patient Information Form

A PLUS DENTISTRY

Patient's Name ____________________________

Do you have Dental Insurance? _______ If yes, name of Dental Insurance Company: ____________________
Do you have Health Insurance? _______ If yes, name of Health Insurance Company: ____________________

Dental Health

Why did you seek dental treatment? ____________________
Are you pleased with the appearance of your smile? _______ Are you interested in our easy, flexible monthly payment Plan? ________

Medical Health

How is your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Who is your physician? Dr. ______________ Address ____________________ Tel. ______________

	y | n
Do you have or have you ever had any major medical problems?	☐☐
Have you ever been hospitalized?	☐☐
Are you now, or have you recently been taking any drug or medication?	☐☐
Are you allergic or sensitive to any drugs or medicine (e.g. penicillin, aspirin)?	☐☐
Do you have any difficulty with bleeding or healing from a cut, wound or extraction?	☐☐
Have you ever been told to pre-medicate with an antibiotic prior to dental treatment, due to a medical condition?	☐☐
Do you have or have you ever had any of the following problems?	☐☐

y | n	y | n	y | n	y | n
☐☐ Rheumatic Fever	☐☐ Allergies	☐☐ Liver Disease	☐☐ Heart Murmur
☐☐ Nervous Disorder	☐☐ Thyroid Problems	☐☐ Heart Disease	☐☐ Angina or Chest Pain
☐☐ High Blood Pressure	☐☐ Stroke	☐☐ Anemia or Blood Disease	☐☐ Lung Disease
☐☐ Asthma	☐☐ Hay Fever	☐☐ Fainting Spells	☐☐ Diabetes
☐☐ Arthritis	☐☐ Cancer	☐☐ Tumors or Growths	☐☐ Kidney Disease
☐☐ Seizure Disorders	☐☐ Sinus Problems	☐☐ Skin Disease	☐☐ Venereal Disease
☐☐ Herpes	☐☐ A.I.D.S.	☐☐ Hepatitis	☐☐ Glaucoma
☐☐ Stomach/Intestinal (Ulcers)	☐☐ Women: Are you pregnant?		

☐☐ None of the above. If yes to any of the above, please explain ____________________

I certify that the foregoing is true and I give permission for any necessary dental treatment.

Signature ______________________________ Date ___/___/______

Doctor's Notes ______________________________

Medical History Updated By	Date	Medical History Updated By	Date

Turn page over

New Patient Information Sheet

Patient's Name (Please Print)	Sex m|f	Date of Birth ___/___/___	Age	Social Security Number	Marital Status s|m|w|d|sep
Street Address ☐ permanent ☐ temporary	City, State, Zip			Home Phone Number	
Patient's Employer (If Student Name of School)	Occupation (If student ☐ full ☐ part-time)			How Long Employed/Year at School	
Employer Street Address	City, State, Zip			Business Phone Number Extension	
Spouse's Name	Date of Birth ___/___/___		Social Security Number	Number of Children and Ages	
Spouse's Employer	Occupation (If student ☐ full ☐ part-time)			How Long Employed/Year at School	
Employer Street Address	City, State, Zip			Business Phone Number Extension	
Close Relative In Case of Emergency	Relationship			Home Phone Number	
Relative's Street Address	City, State, Zip			Cell Phone Number	

If The Patient Is A Minor Or Student

Mother's Name	Street Address	Home Phone Number
Mother's Employer	Occupation	How Long Employed
Employer Street Address	City, State, Zip	Business Phone Number Extension
Father's Name	Street Address	Home Phone Number
Father's Employer	Occupation	How Long Employed
Employer Street Address	City, State, Zip	Business Phone Number Extension

I understand that I am financially responsible for any treatment performed, whether or not I have dental insurance

Signature ______________________________ Date ___/___/______

Insurance Information: If you wish us to process

1st or Primary Insurance Carrier		2nd or Secondary Insurance Carrier		Medical Insurance Carrier	
Employer's Name		Employer's Name		Employer's Name	
Employee/Subscriber Name		Employee/Subscriber Name		Employee/Subscriber Name	
Employee/Subscriber Social Security Number		Employee/Subscriber Social Security Number		Employee/Subscriber Social Security Number	
Patient's Relationship to Subscriber		Patient's Relationship to Subscriber		Patient's Relationship to Subscriber	
Ins. Company Name		Ins. Company Name		Ins. Company Name	
Address		Address		Address	
Group Plan Name	Number	Group Plan Name	Number	Group Plan Name	Number
Certificate/Policy No.	Union/Local No	Certificate/Policy No.	Union/Local No	Certificate/Policy No.	Union/Local No
Deductibles ☐yes	☐no $	Deductibles ☐yes ☐no $		Deductibles ☐yes ☐no $	
Maximum Benefit Per Year $		Maximum Benefit Per Year $		Maximum Benefit Per Year $	

I hereby authorize release of information relating to the treatment necessary to process insurance claims.
I hereby authorize payment directly to A Plus Dentistry Of the Group Insurance Benefits Otherwise Payable to me.

Signature ______________________________ Date ___/___/______

Patients are expected to make payment when services are rendered. The investment necessary to complete dental treatment is an estimate based on information from our examination, should additional problems arise, as treatment progresses, this estimate may be revised. This estimate will be honored for a period of three (3) months only.