New Patient Demographic Information and Health History

Date _____

Personal Information

Patient Name _____ DOB _____
Spouse's/Guardian's Name _____DOB _____
Address _____ Patient SSN_____
City _____ State _____ Zip _____
Phone Numbers:
Home _____ Work _____ Cell _____
Email Address: _____
Name of Emergency Contact _____
Phone Number of Emergency Contact _____

Employer and Insurance Information

Insured Person's Full Name _____
Insured Person's DOB _____ Insured Person's SSN _____
Relationship to Patient _____
Employer of Insured Person _____
Dental Insurance Carrier _____
Group # _____ ID# _____

I give permission for LandMark Dentistry to release information regarding my treatment to my insurance company. I understand that only information regarding the treatment I receive will be released. I also understand that I have the right to request a particular date of service not be billed to my insurance company, and in so doing accept responsibility for payment in full at the time of service. I agree to pay any and all charges not covered by my dental insurance. I also agree to pay my co-payment at the time services are rendered.

_____ _____
Patient/Guardian Signature Date

Dental History

Why did you select our practice for your dental care? _____
_____
_____
Whom may we thank for referring you? _____
What is the date of your last dental visit? _____
What is the date of your last complete dental radiographs? _____
Name and Address of Last Dentist _____
_____
_____
Have you ever had any teeth removed? o yes o no
If yes, when were they removed? _____
Have these teeth been replaced? o yes o no
How? o bridge o partial o denture o implant
What is the main concern about your teeth and mouth? _____
Are you interested in whitening? o yes o no
Are you interested in straightening your teeth? o yes o no
Do you wake up with sore jaws or headaches? o yes o no

Medical History

1. Have you been under the care of a medical doctor in the past two years? o yes o no
   a. If yes, for what reason? _____
2. Please list the medications you are currently taking: _____
   _____
3. Are you sensitive to any of the following?
   _____Penicillin _____Codeine _____Aspirin _____Novocaine _____Anesthetics _____Latex
   _____Other: (please specify) _____
4. Have you ever had excessive bleeding requiring special treatment? o yes o no
5. Do you use any tobacco products? o yes o no
   a. What type/how often: _____
6. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? o yes o no
7. Do your ankles swell during the day? o yes o no
8. Have you lost or gained more than 10 pounds in the last year? o yes o no
9. Are you on a special diet? o yes o no
10. Check any of the following which apply in either past or present:

oMitral Valve Prolapse	oHigh Blood Pressure	oCortisone Medication
oHeart Failure	oAnemia	oArthritis
oHeart Disease or Attack	oAsthma	oPain/Soreness in Jaw Joints
oFamily History of Cardiovascular Disease	oEmphysema	oX-Ray or Cobalt Treatment
oAngina Pectoris (chest pain)	oShortness of Breath	oCancer or Tumors
oRheumatic Fever	oHay Fever	oChemotherapy (Cancer, Leukemia)
oCongenital Heart Lesions	oAllergies or Hives	oThyroid Disease
oScarlet Fever	oFainting or Dizzy Spells	oGlaucoma
oArtificial Heart Valve	oEpilepsy or Seizures	oHIV Posivite (AIDS)
oHeart Pacemaker	oNervousness	oVenereal Disease
oHeart Surgery	oPsychiatric Treatment	oCold Sores or Fever Blisters
oArtificial Joint of Any Type	oEating Disorders	oGenital Herpes
oDiet Medication: _____	oRecreational Drug Use	oKidney Trouble
oHeart Murmur	oAddiction/Alcoholism	oDiabetes
oBruise Easily	oTuberculosis (TB)	oUlcers
oBlood Transfusion	oAny form of Hepatitis	oStroke
oHemophilia	oLiver Disease	oBirth Control: _____
oSickle Cell Disease	oRheumatism	oPregnancy: due date_____

11. Do you have any disease, condition or problem not listed? o yes o no
    a. Please list: _____
12. Are you nervous about having dental treatment? o yes o no
13. Have you ever had a bad experience in a dental office? o yes o no
14. Do your gums bleed at any time? o yes o no
15. Are you having any dental problems at this time? o yes o no
    a. Please explain: _____
16. How do you feel about getting and maintaining a healthy mouth? _____
    _____
17. How do you feel about the appearance of your teeth? _____
    _____
18. If you could change anything about your smile what would it be? _____
    _____

The above information is true and complete to the best of my knowledge.

Patient Signature_____ Date_____