Sloop Dentistry

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New Patient Forms

New Patient Questionnaire

We would love to know more about you.
Please fill us in on the following (optional) information to help us get to know you better.

First Name: ______________________

Middle Name: ______________________

Last Name: ______________________

Nickname: ______________________

Date of Birth: _____-_____-_________
Birthplace ______________________

Where did you grow up? ______________________

Where have you lived as an adult? ______________________

What is your marital status? ______________________

Do you have any children? What are their names and ages? ______________________

What is your educational background? ______________________

What is your vocation? ______________________

What are your hobbies? ______________________

What special interests/activities do you enjoy? ______________________

Is there anything special you would like us to know about you? ______________________

Financing Information

We offer payment plans for our guests through CareCredit. Please complete the following if you would like this option.

First Name: ______________________

Middle Name: ______________________

Last Name: ______________________

Date of Birth: _____-_____-_________

Social Security Number: ________-_______-_________

Present Address
- Street ______________________
- Apt # ______________________
- City ______________________
- State ______________________
- Zip Code ______________________

Home Phone Number: (______)______-________
Employer Phone Number: (______)______-________
Cellular Phone Number: (______)______-________

Housing Info
_____Own
_____Rent
_____Other

Monthly Net Income: ______________________

Nearest Relative Phone Number and Relationship: ______________________

Email address ______________________

Do you have a co-applicant
_____yes
_____no

Date: _____-_____-_________

Signature ______________________________

Health History

First Name:
____

Last Name:
____

Date of Birth: _____-_____-_________

Home Address:
____
____

City:
____

State & Zip Code:
____

Home Telephone:
____

Work Telephone:
____

Cellular Telephone:
____

Physician's Name:
____

Physician's Telephone:
____

Physician's Address:
____
____

Are you under a physician's care now?
_____ yes _____no, I am healthy

For what are you currently seeing a physician?
____
____
____

Have you been hospitalized in the last two years?
_____yes(*please explain*) _____no
____
____

Do you have any current health problems?
_____yes _____no, I am healthy

What medications are you currently taking? Please list current medications and dosages.
____
____
____
____

Do you have any pins or screws in your joints, limbs, skull or anywhere in your body?
_____yes _____no

Where do you have pins or screws
____
____

Do you take premed before dental procedures?
_____yes _____no

Have you ever used tobacco?
_____yes _____no
If yes, please indicate the number of years of use and frequency.
_______years _______/day _______/week

Have you ever received counseling for excessive use of alcohol or prescription drugs?
_____yes (*please explain*) _____no
____
____

Do you bleed excessively upon injury?
_____yes(*please explain*) _____no
____
____

For women (please circle):
Are you
- Pregnant
- Trying to become pregnant
- On birth control
- No

Health History (continued)

Are you aware of being allergic to any medications or substances? If yes, please list:

____

____

Are you allergic to any metals or have you ever had any reaction to metal jewelry? Have you had a skin rash?

____

____

Are you allergic or sensitive to latex?

____yes ____no

Is there any other medical or dental information we should know?

____

Have you ever been involved with any dental or medical legal activity?

____

____

Check any of the following if you have had or presently have:

	Heart Disease or Attack		Hepatitis B (Serum)
	Rheumatic Fever		Hemophilia (bleeding problems)
	Heart Pacemaker		Psychiatric Treatment
	Stroke		Tuberculosis (T.B.)
	Hepatitis A (Infectious)		Allergies or Hives
	Drug Addiction		Arthritis
	Chemotherapy (cancer, leukemia)		Heart Surgery
	Bruise Easily		Venereal Disease
	Hay Fever		Fever Blisters
	Thyroid Disease		Glaucoma
	Pain in Jaw Joints		Asthma
	Angina Pectoris		Diabetes
	Congenital Heart Lesions		Cortisone Medicine
	Nervousness		Cosmetic Surgery
	High Blood Pressure		Heart Murmur
	Mitral Valve Prolapse		Artificial Heart Valve
	Artificial Joints (hip, knee)		Anemia
	Ulcers		AIDS/HIV positive
	Liver Disease		Blood Transfusion
	Kidney Trouble		Epilepsy or Seizures

How long has it been since you have seen a dentist?

____

What was the date of your last complete dental exam?

____-____-________

What can we do for you at your appointment? (the purpose of your visit)

____

____

____

Please check appropriate response

Is your present dental health poor?

____no, it is healthy

____yes, it is poor

Are you apprehensive or nervous about dental treatment?

____no, I am comfortable

____yes, I am apprehensive or nervous

Are your teeth sensitive to hot, cold, sweets, pressure?

____no, my teeth feel fine

____yes, my teeth are sensitive

Are you unhappy with the appearance of your teeth?

____no, my teeth look fine

____yes, my teeth are unattractive

Do you have discolored teeth that bother you?

____no, my teeth are white

____yes, I have discolored teeth

Would you like your smile to look better or different?

____no, I like my smile the way it is

____yes, I would like a better smile

Name of previous dentist

____

City & State

____

How do you feel about your teeth?

____

____

The undersigned hereby authorizes the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of dental needs.

Date: ____-____-________

Signature ______________________________________