Oro-Facial Center

New Patient Form

Today's Date

Patient Name | M / F (Check One) | Date of Birth (DD/MM/YYYY) | Social Security

Street Address | Cell Phone

City | State | Zip | Home Phone

Email Address | Business Phone

Spouse Name | Primary Phone | Secondary Phone

Nearest Relative | Relationship to You | Primary Phone

Street Address of Nearest Relative

Employer Name | Employer Phone

Employer Address

Physician Name | Dentist Name

Physician Street Address | Dentist Street Address

City, State, Zip | City, State, Zip

Physician Phone Number | Dentist Phone Number

Primary Insurance & Address (as shown on back of insurance card)

Name of Insured | Birthdate of Insured | Policy Number

Secondary Insurance & Address (as shown on back of insurance card)

Name of Insured | Birthdate of Insured | Policy Number

Reason for Visit

How did you find out about our office? ☐ Doctor Referral ☐ Family/ Friend ☐ Website ☐ Other

Please list names of person who referred you

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1. Provide the approximate date of last dental exam: _____
2. Provide the approximate date of last physical exam: _____
3. Y N Has there been any change in your general health within the past year?
   If Yes, please describe: _____
   _____
4. Y N Are you under the care of a physician for any illness or condition currently?
   If Yes, please describe: _____
   _____
5. Y N Have you had any tumors operated on?
   If Yes, please describe: _____
   _____
6. Y N Have you received radiation therapy, chemotherapy and/or dialysis?
   If Yes, please describe: _____
   _____
7. Y N If you are a woman, are you pregnant?
   If Yes, what term: _____
8. Do you have or have you ever had any of the following diseases or problems:

	Date	Date	Date
Rheumatic fever	Y N	Y N	Y N
Congenital heart defect	Y N	Y N	Y N
Heart trouble			
High blood pressure	Y N	Y N	Y N
Heart attack	Y N	Y N	Y N
Stroke	Y N	Y N	Y N
Other	Y N	Y N	Y N
Artificial valve	Y N	Y N	Y N
Pace maker	Y N	Y N	Y N
Replacement joints	Y N	Y N	Y N
Allergy	Y N	Y N	Y N
Sinus trouble	Y N	Y N	Y N
Asthma	Y N	Y N	Y N
Seizures	Y N	Y N	Y N
Diabetes	Y N	Y N	Y N
Hepatitis	Y N	Y N	Y N
Jaundice or liver disease	Y N	Y N	Y N
Arthritis	Y N	Y N	Y N
Stomach ulcers	Y N	Y N	Y N
Kidney trouble	Y N	Y N	Y N
Tuberculosis	Y N	Y N	Y N
Venereal disease	Y N	Y N	Y N
Alzheimers/dementia	Y N	Y N	Y N
Aids	Y N	Y N	Y N
Acid Reflux	Y N	Y N	Y N
Other	Y N	Y N	Y N

9. Are you allergic to or have you ever reacted to:

Local anesthesia	Y N	Y N	Y N
Penicillin or other antibiotics	Y N	Y N	Y N
Barbiturates or sedatives	Y N	Y N	Y N
Aspirin	Y N	Y N	Y N
Latex	Y N	Y N	Y N
Other	Y N	Y N	Y N

10. Are you taking any of the following medicines:

Antibiotics	Y N	Y N	Y N
Blood thinners	Y N	Y N	Y N
Diuretics	Y N	Y N	Y N
Cortisone/steroids	Y N	Y N	Y N
Tranquilizers	Y N	Y N	Y N
Antihistamines	Y N	Y N	Y N
High blood pressure	Y N	Y N	Y N
Aspirin	Y N	Y N	Y N
Insulin	Y N	Y N	Y N
Bone density medication	Y N	Y N	Y N
Thyroid medicine	Y N	Y N	Y N
Nitroglycerin	Y N	Y N	Y N
Digitalis	Y N	Y N	Y N
Other	Y N	Y N	Y N

11. Y N Do you premedicate with an antibiotic prior to dental appointment?
    If Yes, what medication & condition: _____

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1. [Y] [N] Do you ever have headaches?
2. [Y] [N] Do you ever have pain, discomfort or other sensations (ringing, roaring, stuffiness, etc.) in or around your ears?
3. [Y] [N] Do you ever have pain, discomfort or other sensations (tiredness, pulling, stiffness, weakness, burning, dryness, etc.) about the face, eyes, neck, shoulders, mouth or throat?
4. [Y] [N] Does it ever hurt to chew, a tooth get in the way when you close, your teeth don't "fit" or is your bite ever uncomfortable?
5. [Y] [N] Does it ever hurt to open wide, take a big bite or have any difficulty in opening your mouth?
6. [Y] [N] Does your jaw joint ever hurt, pop, grate, catch, lock bind, etc.?
7. [Y] [N] Are you aware that you clench, grind, clasp, set your teeth or brace, set, position your jaws either day or night?
8. [Y] [N] Do you ever wake up with a stiff jaw, tired muscles, sore face, sore teeth, etc.?
9. [Y] [N] Do you feel that you are under any stress, tension or anxiety?

To the best of my knowledge the above medical and dental information that I provided is correct.

I understand that this office has a broken appointment fee $50 per hour as well as a return check fee of $75.

Patient or Guardian Signature

Today's Date

Practice Philosophy

"To do unto you the same quality of care as we would do unto members of our own families"