Welcome to Mt. Angel Dental

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. So that we can serve you better, please complete both sides of this new patient history form.

PATIENT INFORMATION

Patient's Name _____ Today's Date _____
How do you wish to be addressed? _____
Birthdate _____ Social Security # _____ Sex □ Female □ Male □ Other _____
Marital status: □ Married □ Widowed □ Single □ Minor □ Separated □ Divorced □ Partnered for _____ years
Home Phone (____) _____ Cell Phone (____) _____ E-mail _____
Would you like to receive Email reminders? Yes/No Text Message reminders? Yes/No
Address _____ City _____ State _____ Zip _____
If patient is a minor, please give parent's or guardian's name _____
Emergency contact _____ Phone number _____
Whom may we thank for referring you? _____

RESPONSIBLE PARTY/BILLING INFORMATION

Name _____ Relationship to patient _____
Address _____ City _____ State _____ Zip _____
Mailing Address (if different than above) _____
How long at this address _____ Home Phone (____) _____ Work Phone (____) _____ Ext _____
Previous address (if less than 3 years) _____ How long at this address? _____
Social Security # _____ Birthdate _____
Employer _____ Occupation _____ No. Years Employed _____
Spouse's Name _____ Birthdate _____ Social Security # _____
Employer _____ Occupation _____ Years Employed __ Work Phone _____

INSURANCE INFORMATION

Name of insured _____ Birthdate _____ Social Security # _____
Insurance Company _____ Group No. _____ I.D. # _____
Insurance Company Address _____
Employer _____ Work Phone (____) _____
Do you have dual coverage? _____ Yes _____ No If yes, please fill in the following:
Name of insured _____ Birthdate _____ Social Security # _____
Insurance Company _____ Group No. _____ I.D. # _____
Insurance Company Address _____
Employer _____ Work Phone (____) _____

CONSENT FOR TREATMENT

I hereby authorize Mount Angel Dental to administer any treatment and to administer such x-rays, anesthetic, and to perform such dental procedure as may be deemed necessary or advisable in the diagnosis and treatment of my dental condition. I authorize information to be released relating to any dental claims. I realize that I am ultimately responsible for all costs of dental treatment. I understand the use of anesthetic embodies a certain risk. I hereby authorize my insurance benefits to be paid directly to Mount Angel Dental.

Date _____ Signature (patient or parent/guardian for minor) _____

MEDICAL HISTORY

Patient's Name _____
Physician's Name _____
Name of the Practice they are located at _____
Phone Number (____) _____ Date of last visit _____
Have you been hospitalized in the last 2 years? _____ For? _____
(Women) are you pregnant? □ Yes □ No Nursing? □ Yes □ No Taking birth control pills? □ Yes □ No
Please list all medication and drugs you are taking _____
_____
Have you ever had an adverse reaction or allergies to any medication or substance? (Please circle)

Aspirin	Valium	Sulfa Drugs	Penicillin	Novocain	Nitrous Oxide	
Codeine	Iodine	Tetracycline	Erythromycin	Xylocaine	Latex	Other _____

Check (✓) if you have had any of the following:

- □ Anemia
- □ Arthritis, Rheumatism
- □ Artificial Heart Valves
- □ Artificial Joints, Pins
- □ Asthma
- □ Back Problems
- □ Blood Disease
- □ Blood Transfusion
- □ Bruise Easily
- □ Cancer
- □ Chemical Dependency
- □ Chemotherapy
- □ Circulatory Problems
- □ Cold Sores
- □ Congenital Heart Problems
- □ Cortisone Treatments
- □ Cough, Persistent
- □ Cough up Blood
- □ Diabetes
- □ Dizziness or Fainting
- □ Drug/Alcohol Addiction
- □ Eating Disorder
- □ Emphysema
- □ Epilepsy or Seizures
- □ Frequent Thirst
- □ Frequent Urination
- □ Glaucoma
- □ Headaches
- □ Heart Attack
- □ Heart Murmur
- □ Heart Problems
- □ Heart Valve or Pacemaker
- □ Hemophilia
- □ Herpes
- □ Hepatitis (type:)
- □ High / Low Blood Pressure
- □ HIV – AIDs - ARC
- □ Hypoglycemia
- □ Jaw Pain
- □ Kidney Disease
- □ Liver Disease
- □ Lung Disease
- □ Mitral Valve Prolapse
- □ Psychiatric Care
- □ Respiratory Disease
- □ Scarlet Fever
- □ Shortness of Breath
- □ Sinus Problems
- □ Skin Rash
- □ Stroke
- □ Swelling of Feet or Ankles
- □ Thyroid Problems
- □ Tobacco Habit
- □ Tonsilitis
- □ Tuberculosis
- □ Tumor or Growth
- □ Ulcer or G.I. Problems
- □ Venereal Disease

Do you have any conditions or problems not listed above which we should know about? _____
Please Explain _____

DENTAL HISTORY

What are your present dental concerns? _____
When did you last see a dentist? _____ When did you last have a dental X-ray?_____
Have you avoided regular dental care? ___ Yes ___ No Why? _____
Do you feel you have active decay? ___ Yes ___ No Do you feel you have gum diseases? __ Yes __ No
Have you ever had any periodontal (gum) treatments? ___ Yes ___ No
How often do you brush? _____ Floss? _____ Use other cleaning aids? _____
Are you happy with the appearance of your teeth? ___ Yes ___ No
Would you like your teeth to be whiter? ___ Yes ___ No
What are your dental expectations? _____
Previous dentist? _____ Name of Practice _____
City _____ State _____ Phone Number (____) _____
Would you like us to request your records from your pervious dentist? ___ Yes ___ No