FAMILY KARE DENTAL

NEW PATIENT PAPERWORK

Please complete all sections as accurately as possible.

PATIENT INFORMATION

First Name: _____ Last Name: _____

Date of Birth: _____ Gender: _____ Marital Status: _____

Mailing Address: _____

City: _____ State: _____ ZIP Code: _____

Best Contact Phone: _____ Can we text you? ☐ Yes ☐ No

Email Address: _____

How did you hear about us? _____

Emergency Contact Name: Phone:

_____ _____

RESPONSIBLE PARTY / GUARANTOR

Name: _____ Relationship: _____

Phone: _____ Date of Birth: _____

Address (if different): _____

DENTAL INSURANCE INFORMATION

Insurance Company: _____

Subscriber/Member Name: _____ Relationship to Patient: _____

Member/ID #: _____ Group #: _____ Subscriber Date of Birth: _____

MEDICAL HISTORY

List all medications you are currently taking:

_____

_____

Are you allergic to any of the following? Check all that apply:

☐ Anesthetic ☐ Aspirin ☐ Codeine ☐ Ibuprofen ☐ Iodine ☐ Latex ☐ Penicillin ☐ Sulfa

Other: _____

Do you have any of the following medical conditions? Check all that apply:

☐ Asthma	☐ Bleeding Problems	☐ Cancer
☐ Diabetes	☐ Heart Murmur	☐ Heart Trouble
☐ High Blood Pressure	☐ Joint Replacement	☐ Kidney Disease
☐ Liver Disease	☐ Psychiatric Treatment	☐ Sinus Trouble
☐ Stroke	☐ Ulcers	☐ Rheumatic Fever

Pregnant: ☐ No ☐ Yes

If yes, how far along? _____

Other medical conditions you think we should know about: _____

_____

Do you use any recreational drugs? _____ Do you smoke? _____

Primary Care Physician: _____

Preferred Pharmacy Name: _____ Phone: _____

DENTAL HISTORY

Reason for changing dentist: _____

Why are you here today? _____

Do you have dental anxiety? ☐ Yes ☐ No How long since last dental appointment? _____

Have you ever had a bad reaction to dental anesthetic? ☐ Yes ☐ No

Have you had any complications following dental work? ☐ Yes ☐ No

Are your teeth sensitive to hot or cold? ☐ Yes ☐ No

Do your gums bleed when you brush or floss? ☐ Yes ☐ No

Are you aware of any sores or irritated areas in your mouth? ☐ Yes ☐ No

Do you grind your teeth? ☐ Yes ☐ No

Have you ever been diagnosed with periodontal disease? ☐ Yes ☐ No

How often do you brush? _____ How often do you floss? _____

Do you like your smile? ☐ Yes ☐ No

PERMISSION TO DISCUSS DENTAL INFORMATION

☐ **YES** I give permission/consent to Family Kare Dental to discuss any and all dental information with the named individuals below:

Name: _____

Relationship: _____ Phone: _____

☐ **NO** I do not wish Family Kare Dental to discuss any of my dental treatment with anyone other than me.

ACKNOWLEDGMENT

By signing below, I confirm that the information provided in this paperwork is correct to the best of my knowledge.

Patient/Parent/Guardian Signature: _____ Printed Name: _____ Date: _____