NEW PATIENT FORM

Patient Name (Last, First, Middle)

Date of Birth (MM/DD/YYYY)

Gender: ☐ Female ☐ Male

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Social Security # | Driver's License #

Street Address

City | State | Zip Code

Spouse's Name

Cell Phone # | Alternate Phone #

Children's Names & Ages

Email Address

Emergency Contact Name

Name of Employer | Occupation

Emergency Contact Cell Phone #

Name of School / College | Grade

Preferred Pharmacy / Phone #

Preferred Method of Communication: ☐ Email ☐ Text ☐ Cell # ☐ Alternate #

You will be contacted via phone, text message and email in regard to upcoming appointments, treatment documents, and/or payment unless preferred method of communication specified.

How did you hear about us? ☐ Current Patient ☐ Your Insurance ☐ Mail / Brochure ☐ Online ☐ Other

INSURANCE INFORMATION

Policy Holder's Name (Last, First, Middle) | Relationship to Patient

Dental Insurance Company

Policy Holder's Social Security # | Policy Holder's Date of Birth

Insurance Company Phone #

Policy Holder's Employer | Employer's Phone #

Group Insurance # / Group ID #

PATIENT DENTAL HISTORY

Reason for Today's Visit

Date of Last Dental Cleaning

Name of Previous DDS | City of Previous DDS

How many times per week do you floss?

Date of Last Dental Visit | What was done?

How many times per week do you brush?

Have you had any of the following (check all that apply):

☐ Gums bleed while brushing or flossing
☐ Teeth sensitive to hot or cold liquids/foods
☐ Teeth sensitive to sweet or sour liquids/foods
☐ Feel pain to any of your teeth
☐ Sores or lumps in/near your mouth
☐ Experience clicking in your jaw
☐ Aware of clenching or grinding your teeth
☐ Pain in face / cheeks / jaw / throat / temples
☐ Hurts to chew or open wide to take a bite

PATIENT MEDICAL HISTORY

Health problems that you may have or medication you are currently taking could have an effect on the dental care you receive. Please answer the following.

If you are currently under the care of a physician, please provider their name. Physician's Phone #

Have there been any changes in your general health within the past year? *If yes, please explain.* Date of Last Physical

Have you ever been hospitalized or had a major operation? *If yes, please explain.*

Do you use tobacco (in any form)? *If yes, please explain.*

Do you use controlled substances? *If yes, please explain.*

Are you allergic to any substances and / or medications? *If yes, please explain.*

Please list any medication you are taking, including non-prescription medications, and the reason for use:

WOMEN ONLY (check all that apply): ☐ Pregnant or think your may be pregnant? ☐ Are you nursing? ☐ Are you on birth control pills?

Do you have / have you ever had any of the following (check all that apply):

- ☐ Abnormal Bleeding
- ☐ Abnormal Blood Pressure
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis / Gout
- ☐ Asthma
- ☐ Biomedical Implants
- ☐ Cancer
- ☐ Congenital Heart Disease
- ☐ Diabetes
- ☐ Epilepsy / Seizures
- ☐ Fainting Spells
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hepatitis (A/B/C)
- ☐ HIV / AIDS
- ☐ Jaundice
- ☐ Orthopedic Prosthesis
- ☐ Mitral Valve Prolapse
- ☐ Rheumatism
- ☐ Sinus Trouble
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcers / GI Disorders
- ☐ X-Ray Treatments for Cancer

If you checked any of the above, please explain.

AUTHORIZATION AND RELEASE

To the best of my knowledge, the information provided is complete and correct. I understand it is my responsibility to inform the office about any changes to my insurance.

I certify that I, and/or my dependent(s), have insurance coverage with ______________________ and assign directly ______________________ to all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Rubab Mirrza may use my health care information and may disclose such information to the named Insurance company(ies) and their agents for the purposes of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I acknowledge that I have been made aware of this office's Notice of Privacy Practices and Financial Policy. I may refuse to sign this acknowledgment if I wish.

Signature of Patient (or Parent / Guardian, if Minor) Date

Signature of Doctor Date