Signature Dentistry and Dental Implants

DATE:_____

NEW PATIENT INFORMATION

NAME:_____ SSN:_____

ADDRESS:_____ DRIVER'S LICENSE NUMBER:_____

CITY:_____ STATE:_____ ZIP CODE:_____ BEST PHONE NUMBER:_____

EMAIL ADDRESS:_____

DATE OF BIRTH:_____ GENDER: M / F MARITAL STATUS:_____

EMERGENCY CONTACT:_____ PHONE NUMBER:_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE:_____

EMPLOYER INFORMATION

EMPLOYER NAME:_____ OCCUPATION:_____

PRIMARY DENTAL INSURANCE INFORMATION

NAME OF DENTAL INSURANCE :_____ INSURANCE ID #:_____

INSURANCE SUBSCRIBER:_____ REALTIONSHIP TO PATIENT:_____

INSURANCE SUBSCRIBER DOB:_____ INSURANCE COMPANY PHONE NUMBER:_____

PRIMARY MEDICAL PROVIDER INFORMATION

PRIMARY CARE PHYSICIAN NAME:_____ PHONE NUMBER:_____

PHYSICIAN ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

WE REQUEST A COPY OF YOUR IDENTIFICATION, DENTAL INSURANCE CARD, AND A LIST OF CURRENT MEDICATIONS.

CIRCLE IF YOU HAVE/HAD ANY OF THE FOLLOWING:

SNORING	MORNING HEADACHES	TIREDNESS DURING THE DAY
ACID REFLUX / GERD	JAW PAIN / CLICKING	GRINDING TEETH ANXIETY / DEPRESSION
BLEEDING GUMS	POLYCYSTIC OVARIAN SYNDROME	TOOTH SENSITIVITY: HOT / COLD / SWEETS / BITING
MOOD DISTURBANCE	SUBSTANCE ABUSE	FREQUENT URINATION DURING SLEEPING HOURS
IRRITABLE BOWEL SYNDROME	ERECTILE DYSFUNCTION	STOP BREATHING WHILE SLEEPING/APNEA
WEIGHT GAIN	INSOMNIA	RESTLESS LEG SYNDROME

MEDICATIONS:					ALLERGY TO:
	AIDS / HIV POSITIVE	DIABETES	KIDNEY DISEASE	SHORTNESS OF BREATH	
	ANAPHALAXIS	EPILEPSY	LIVER DISEASE	SKIN CONDITIONS	**ASPIRIN**
	ANEMIA	GLAUCOMA	NERVOUS PROBLEMS	STROKE	**CODEINE**
	ARTHRITIS	HEART MURMUR/MVP	PACEMAKER	SURGICAL IMPLANTS	**CLINDAMYCIN**
	ARTIFICAL JOINTS / VALVES	HEART PROBLEMS	CURRENTLY PREGNANT OR NURSING	SWELLING OF FEET /ANKLES	**HAY FEVER**
	ASTHMA	HEMOPHILIA	PSYCHIATRIC CARE	THYROID DISEASE	**LATEX**
	BACK PROBLEMS	HEPATITIS: A B C	RADIATION TREATMENT	TOBACCO HABIT	**PENICILLIN**
	CANCER	HERPES	RESPIRATORY DISEASE	TUBERCULOSIS	**SULFA**
	CHEMOTHERAPY	HIGH BLOOD PRESSURE	RHEUMATIC/SCARLET FEVER	ULCERS / COLITIS	**IODINE**
	CIRCULATORY PROBLEMS	HPV	SHINGLES	SEXUALLY TRANSMITTED DISEASES	**OTHER:**_____

TO THE BEST OF MY KNOWLEDGE, THE QUESTIONS ON THIS FORM HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY (OR PATIENT'S) HEALTH. IT IS MY RESPONSIBILITY TO INFORM DR. SOMMERS' OFFICE OF ANY CHANGES IN MY MEDICAL STATUS INCLUDING CHANGES IN MY MEDICATIONS.

SIGNATURE OF PATIENT / PARENT / GUARDIAN / POWER OF ATTORNEY

SIGNATURE OF PATIENT:_____ **DATE:**_____

SIGNATURE OF PROVIDER:_____ **DATE:**_____