We would like to get to know you better!

New Health Dental Kendall Roberts, DDS, P.C. Beau Sparkman, DDS, P.A. Palwasha Sherwani, DDS

PERSONAL INFORMATION Date ____________________

First name ______________________________ Middle Initial _____ Last name ______________________________

◯ Male ◯ Female

Patient's SS # __________-_______-__________ DL# ____________________________ DOB _____/_____/________

Street address ____

City/state/zip ____

E-mail address ____

Home phone ____________________ Work phone ______________________ Cell phone _______________________

If child: Parent's name ____________________ Middle Initial _____ Last name ______________________________

DOB _____/_____/________ SS # __________-_______-__________

Street Address: ____

City/state/zip ____

Employer ______________________________ Phone ____________________ Occupation ____________________

Spouse's name __________________________________ SS # ________-____-________ DOB _____/_____/________

Employer ___________________________ Phone ____________________ Occupation

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Emergency contact _____________________________ Relationship _________________ Phone

____

How were you referred to our office?

◯ Friend/family: name _________________________ ◯ Radio ◯ Television ◯ Phonebook ◯ Website/internet

◯ Insurance provider list Social media: ◯ Facebook ◯ Twitter ◯ other

____

FOR INSURANCE PURPOSES

Insurance company ____ Subscriber name_____

____

SS#/id# ____________________________________ DOB _____/_____/_____ Group #

____

Are you covered by another plan? __________ Insurance company

____

Subscriber name_____ ______________________________ SS#/id#

________________________________ DOB _____/_____/_____ Group #

____

Are your teeth sensitive to:	YES	NO
Hot?	◯	◯
Cold?	◯	◯
Sweets?	◯	◯
Biting pressure?	◯	◯
Does food catch btwn your teeth?	◯	◯
Do your gums bleed when brushing?	◯	◯
Have you noticed any gum swelling around any teeth?	◯	◯
Do you have an unpleasant taste or odor in your mouth?	◯	◯

Problems of the jaw:

Clicking of the jaw	◯	◯
Pain (joints/eat/side of face)	◯	◯
Difficulty opening or closing	◯	◯
Difficulty chewing	◯	◯
Do you ever avoid any part of the mouth while brushing?	◯	◯
Have you had a reaction to local anesthetic?	◯	◯
Are you dissatisfied with your teeth & their appearance?	◯	◯

Are you deeply concerned about the finances required to return your mouth to excellent health? ◯◯

Do you get frustrated because you always have something to be treated or repaired when you visit a dentist? ◯◯

Do you smoke? ◯◯

Have you ever had any teeth removed? ◯◯

How long have these teeth been missing?

____

Do you feel you will eventually wear artificial dentures? ◯◯

Do you have fears? ◯◯

SIGNATURE

When was your ______________________________

____________ ____________

Do you have any general health problems? ◯◯

If so, please specify

____

____

____

Have you had surgery? ◯◯

If so, please specify

____

____

____

Are you currently under a physician's care? ◯◯

Reason

____

____

____

Do you take any medications? ◯◯

Please list

____

____

____

To the best of your knowledge, are you or have you ever been afflicted with:

Heart ailment ◯◯

Diabetes ◯◯

Rheumatic fever ◯◯

Epilepsy ◯◯

High blood pressure ◯◯

Respiratory disease ◯◯

Hepatitis ◯◯

HIV positive ◯◯

Prolonged bleeding ◯◯

Healing complications ◯◯

Allergy to any drugs ◯◯

If yes, please specify

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Allergic to latex? ◯◯

Are you pregnant? ◯◯

If yes, month

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