Newcastle Dentistry

Patient's First Name:_____ Last Name:_____ Middle Initial:____ Preferred Name:_____
Patient is: □ Policy Holder □ Responsible Party
Address:_____ City:_____ State:_____ Zip:_____
Home Phone:_____ Work Phone: _____ Cell Phone:_____
Sex: □ Male □ Female Marital Status: □ Married □ Single □ Divorced □ Separated □ Widowed
Date of Birth:_____ SSN:_____ Email:_____ Email confirmations? Yes □ No □
Employer:_____ Emergency Contact:_____ Phone:_____

Responsible Party (if other than patient) First Name: _____ Last Name:_____ Middle Initial:___
Relationship to Patient: □ Self □ Spouse □ Parent □ Other Responsible Party Date of Birth:_____
SSN:_____
Address:_____ City:_____ State:_____ Zip:_____
Employer:_____ Email:_____

Primary Insurance Company:_____
Policy Holder's relationship to Patient: □ Patient □ Spouse □ Parent □ Other
If not Patient, Insured's Name:_____ Employer: _____ Date of Birth:_____
SSN:_____ Group #:_____ ID #:_____

Secondary Insurance Company:_____
Policy Holder's relationship to Patient: □ Patient □ Spouse □ Parent □ Other
If not Patient, Insured's Name:_____ Employer:_____ Date of Birth:_____
SSN:_____ Group #:_____ ID #:_____

Personal

How did you hear about our office (referral source)?_____
How can we make your visit the best you have had?_____

Dental Information

Reason for today's visit: _____ Date of last dental exam:_____
What was done at your last visit?_____
How often do you brush?_____ Floss?_____

Are any of your teeth sensitive to hot or cold? □ Yes □ No
Are any of your teeth sensitive to sweets or pressure? □ Yes □ No
Ever had problems with local anesthetic? □ Yes □ No
Are you concerned about bad breath? □ Yes □ No
Would you like your teeth whiter? □ Yes □ No
Are you concerned about chips in your teeth? □ Yes □ No
Have you been treated for gum disease? □ Yes □ No
Have you ever had an unfavorable dental visit? □ Yes □ No

Authorizations and Consent

AUTHORIZATION FOR TREATMENT AND SURGICAL CARE: I hereby grant permission to the staff of Newcastle Dentistry to employ such established treatments and therapy as may be deemed professionally necessary or advisable. I understand that when I make an appointment, I am advance purchasing this time. I agree to give 48 business hours' notice if I cannot keep my appointment.

Parent/Guardian or Patient Signature: _____ Date: _____ Staff Initials:_____

Patient Health History

Patient Name:_____ Birth Date:_____

Are you under a physician's care now □Yes □No
If yes, please explain:_____

Have you ever been hospitalized or had a major operation? □Yes □No
If yes, please explain:_____
_____

Are you taking any medications, pills, or drugs? □Yes □No
If yes, please list drugs and what they are for:_____
_____

Have you ever taken Fosamax, Boniva, Actonel, or any other drugs containing bisphosphonates? □ Yes □ No
Are you taking any blood thinners (eg. Coumadin, Eliquis, Xarelto, etc.)? □ Yes □ No
Do you use controlled substances? □Yes □No
Do you use tobacco?. □Yes □No If yes, how often and what type:_____

WOMEN- Are you: □Pregnant/Trying to get Pregnant? □Nursing? □Taking oral contraceptives?

Are you allergic to any of the following?
□ Aspirin □ Penicillin □ Codeine □ Acrylic □ Metal □ Latex □ Local Anesthetics □ Sulfa Drugs
□ Other—If yes, please explain:_____

Do you have, or have you had, any of the following?

□ AIDS/HIV
□ Alzheimer's disease
□ Anemia
□ Angina
□ Arthritis/ Gout
□ Artificial Heart Valve
□ Artificial Joint
□ Asthma
□ Breathing Problems
□ Bruise Easily
□ Cancer
□ Chemotherapy and/or Radiation
□ Cold Sores/Fever Blisters
□ Congenital Heart Disorder
□ Diabetes (Type 1 or 2?)
□ Drug Addiction
□ Epilepsy or Seizures
□ Excessive Bleeding
□ Fainting Spells/Dizziness
□ Frequent Headaches
□ Glaucoma
□ Heart Pace Maker
□ Heart Murmur
□ Heart Attack/ Failure
□ Hepatitis A
□ Hepatitis B or C
□ Herpes Type I
□ Herpes Type II
□ High Cholesterol
□ High Blood Pressure
□ Hemophilia
□ Irregular Heartbeat
□ Kidney Problems- Dialysis?
□ Leukemia
□ Lichen Planus
□ Liver Disease
□ Lung Disease
□ Mitral Valve Prolapse
□ Osteoporosis
□ Psychiatric Care
□ Sinus Trouble
□ Sjogren's Disease
□ Stroke
□ Thyroid Disease
□ TMJ issues

Have you ever had any serious illness not listed above? □Yes □No If yes, please explain:_____
_____

Date of your last medical examination:_____ Physician's Name: _____Physician's Phone Number: _____

To the best of my knowledge, the questions on the 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 the dental office of any changes in medical status

Patient or Parent/Guardian Signature:_____ Date:_____ Staff Initial: _____