DR. DIAS FAMILY DENTISTRY

NEW PATIENT FORM

Welcome to our practice! Please take a few minutes to answer the following questions so we can better assist you with your dental records. Once you have completed this form, you may print them out and bring them to your first appointment or email them to diasfamilydentistry@gmail.com. Thank you!

PATIENT INFORMATION

Date _____ Soc. Sec. # _____ DOB _____

Name _____ Home Phone _____
Last Name First Name Initial

Address _____ Cell Phone _____

City _____ State _____ Zip _____ Email _____

Sex ☐M ☐F ☐Minor ☐Single ☐Married ☐Long Term Partner ☐Divorced ☐Widowed ☐Separated

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Emergency Contact _____ Phone _____

PRIMARY DENTAL INSURANCE

Person Responsible for Account _____
Last Name First Name Initial

Relationship to Patient _____ DOB _____ Soc. Sec. # _____

Address _____ Phone _____

City _____ State _____ Zip _____

Responsible Party Employer _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D.# _____ Group # _____

ADDITIONAL INSURANCE

Person Responsible for Account _____
Last Name First Name Initial

Relationship to Patient _____ DOB _____ Soc. Sec. # _____

Address _____ Phone _____

City _____ State _____ Zip _____

Responsible Party Employer _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D.# _____ Group # _____

PLEASE COMPLETE REVERSE SIDE

DENTAL HISTORY

Former Dentist _____ Date of Last X- Rays_____

City, State _____ How Often Do You Floss? _____

Date of Last Dental Visit _____ How Often Do You Brush? _____

PLEASE CHECK ALL THAT APPLY:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Blisters on Lips or Mouth
- ☐ Finger Nail Biting
- ☐ Griding Teeth
- ☐ Lip or Cheek Bleeding
- ☐ Loose Teeth or Broken Fillings
- ☐ Orthodontic Treatment
- ☐ Pain Around Ear
- ☐ Periodontal Treatment
- ☐ Sensitivity to Cold
- ☐ Sensitivity to Heat
- ☐ Sensitivity to Sweets
- ☐ Sensitivity When Biting
- ☐ Frequent Headaches
- ☐ Jaw, Head or Neck Injuries
- ☐ Jaw Difficulty: Clicking and/or Pain
- ☐ Tooth Pain

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

1. Are you currently under medical treatment? Y / N
2. Have you ever had any serious illnesses or operations? Y / N
3. Are you currently taking any medications? Y / N

Please describe _____

_____

4. Do you smoke? Y / N
5. Do you use alcohol, cocaine, or other drugs? Y / N
6. Do you wear contact lenses? Y / N

7. Have you had any allergic reaction to:

- ☐ Local Anesthetics (e.g. Novocaine)
- ☐ Penicillin or other Antibiotics
- ☐ Sulfa Drugs
- ☐ Barbiturates (sleeping pills)
- ☐ Sedatives
- ☐ Iodine
- ☐ Aspirin
- ☐ Other _____

WOMEN ONLY:

Are you pregnant? Y / N Are you nursing? Y / N Taking birth control pills? Y / N

PLEASE CHECK ALL THAT APPLY:

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding abnormally w/ surgery
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Chronic Fatigue Syndrome
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatments
- ☐ Cough - persistent or bloody
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting or Dizziness
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis-Type _____
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Jaundice
- ☐ Jaw Pain
- ☐ Latex Sensitivity
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet/Ankles
- ☐ Swollen Neck Glands
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor or growth on head/neck
- ☐ Ulcer
- ☐ Venereal Disease

ASSIGNMENT & RELEASE

I hereby authorize payment directly to Dr. Thomas Dias for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____