

New Patient Information Form

Patient Information:

Patient First Name

Patient Last Name

Gender

☐ Male

☐ Female

☐ Other

D.O.B:

Preferred Name(S)

Parent/Guardian Last Name

Parent/Guardian First Name

Parent/Guardian DOB

Parent/Guardian Social Security #

Driver's License #

Home Address

City

State

☐ Alabama

☐ Alaska

☐ Arizona

☐ Arkansas

☐ California

☐ Colorado

☐ Connecticut

☐ Delaware

☐ Florida

☐ Georgia

☐ Hawaii

☐ Idaho

☐ Illinois

☐ Indiana

☐ Iowa

☐ Kansas

☐ Kentucky

☐ Louisiana

☐ Maine

☐ Maryland

☐ Massachusetts

☐ Michigan

☐ Minnesota

☐ Mississippi

☐ Missouri

☐ Montana

☐ Nebraska

☐ Nevada

☐ New Hampshire

☐ New Jersey

☐ New Mexico

☐ New York

☐ North Carolina

☐ North Dakota

☐ Ohio

☐ Oklahoma

☐ Oregon

☐ Pennsylvania

☐ Rhode Island

☐ South Carolina

☐ South Dakota

☐ Tennessee

☐ Texas

☐ Utah

☐ Vermont

☐ Virginia

☐ Washington

☐ West Virginia

☐ Wisconsin

☐ Wyoming

☐ Puerto Rico

☐ District of Columbia

☐ US Virgin Islands

Zip Code

Home Phone

Cell Phone

Work Phone

Email Address

Whom may we thank for your referral?

☐ Another Patient/Friend

Name of That Person

- ☐ Internet Search
- ☐ Specialist Recommendation
- ☐ Physician Name

Medical Information:

Name of Treating Medical Provider: Phone

Have you ever had any of the following?

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

Medical Conditions

- ☐ Allergies
- ☐ Arthritis
- ☐ Cancer
- ☐ Fainting
- ☐ Glaucoma
- ☐ Kidney Disease
- ☐ Migraines
- ☐ Radiation Treatment
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Rheumatic Fever
- ☐ Pacemaker
- ☐ ADHD
- ☐ Artificial Joints
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Hepatitis
- ☐ Liver Disease
- ☐ Nervous Disorders
- ☐ Respiratory Problems
- ☐ Stomach Problems
- ☐ Thyroid Condition
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Anemia
- ☐ Asthma
- ☐ Dizziness
- ☐ Seizures
- ☐ HIV
- ☐ Jaundice
- ☐ Panic Attacks/ Anxiety
- ☐ Sinus Problems
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ High Blood Pressure

Artificial Joint(s) – Type and Year: Hepatitis – Type:

- ☐ Abnormal Bleeding
- ☐ Dementia or Alzheimer’s
- ☐ Emotional Problems
- ☐ Immunosuppressive Disorders
- ☐ Osteoporosis
- ☐ Tobacco Use
- ☐ ALS
- ☐ Depression
- ☐ Frequent Headaches
- ☐ Lyme Disease
- ☐ Parkinson’s Disease
- ☐ Blood Clot
- ☐ Drug or Alcohol Abuse
- ☐ Hearing Difficulties
- ☐ MS
- ☐ Stomach Ulcer/Colitis

Type & Amount:

- ☐ STD
- ☐ Irregular Heart Beat
- ☐ Artificial Heart Valve(s)
- ☐ Heart Attack
- ☐ Congestive Heart Failure
- ☐ High Cholesterol
- ☐ Congenital Heart Lesion
- ☐ Bacterial Endocarditis
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse

Year:

- ☐ Angina/Chest Pain

Are you allergic to any of the following?

Are you allergic to any of the following?

Allergies

☐ Allergy - Aspirin

☐ Allergy - Codeine

☐ Allergy - Latex

☐ Allergy - Penicillin

☐ Allergy - Sulfa

☐ Allergy - Other

☐ Amoxicillin

☐ Clindamycin

☐ Local anesthetic (Novocain)

☐ Seasonal (dust, pollen, dander)

☐ Food:

☐ Other

Are you using any of the following medications?

☐ *Pre-Med - Amox

☐ *Pre-Med - Clind

☐ *Pre-Med - Other

Have you been admitted to a hospital, had surgery or needed emergency care in the past two years?

☐ Yes

☐ No

If yes, please explain:

Please list any other health concerns that need further discussion:

Patient Name:

Authorizations:

I authorize release of information to all of my insurance companies.

I agree to pay for services rendered at the time of treatment.

I agree that I am ultimately responsible for my bill.

I authorize Soaring Smiles Pediatric Dentistry and team to act as my agent in helping me to obtain payment from my Insurance companies.

I authorize payment directly to Soaring Smiles Pediatric Dentistry

I consent to all necessary dental procedures as deemed appropriate by Dr. Jonathan Smith

Signed

Date: