New Bite
DENTISTRY & ORTHODONTICS

PATIENT INFORMATION	CONFIDENTIAL
NAME ______	BIRTHDATE ______
ADDRESS ______	HOME PHONE ______
CITY ______ STATE ______ ZIP ______	CIRCLE APPROPRIATE SELECTION:
PATIENT OR PARENT'S EMPLOYER ______	MINOR SINGLE MARRIED
BUSINESS ADDRESS ______	DIVORCED WIDOWED SEPARATED
CITY ______ STATE ______ ZIP ______	WORK PHONE ______
IF PT IS A STUDENT, NAME OF SCHOOL ______	CELL PHONE ______
CITY ______ STATE ______	OTHER ______
WHOM MAY WE THANK FOR REFERRING YOU? ______	EMAIL ______
______	
RESPONSIBLE PARTY	
NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT ______	RELATIONSHIP TO PATIENT ______
______	HOME PHONE ______
ADDRESS ______	WORK PHONE ______
CITY ______ STATE ______ ZIP ______	CELL PHONE ______
EMPLOYER ______	BIRTHDATE ______
ADDRESS ______	SS NUMBER ______
CITY ______ STATE ______ ZIP ______	
INSURANCE INFORMATION	
NAME OF INSURED ______	RELATIONSHIP TO PATIENT ______
INSURANCE COMPANY ______	BIRTHDATE ______
ADDRESS ______	SS NUMBER ______
CITY ______ STATE ______ ZIP ______	GROUP NUMBER ______
	INSURANCE PHONE ______

ADDITIONAL INSURANCE

NAME OF INSURED ____

INSURANCE COMPANY ____

ADDRESS ____

CITY ________________________ STATE ______________ ZIP __________

RELATIONSHIP TO PATIENT _________

BIRTHDATE _____________________

SS NUMBER _____________________

GROUP NUMBER ___________________

INSURANCE PHONE _______________

PATIENT MEDICAL HISTORY

PHYSICIAN NAME ____

- ARE YOU UNDER THE CARE OF A PHYSICIAN YES NO
- HAVE YOU BEEN HOSPITALIZED IN THE LAST FIVE YEARS YES NO
- ARE YOU TAKING MEDICATIONS? INCLUDING OVER THE COUNTER AND PRESCRIPTION. YES NO
- DO YOU USE TOBACCO? YES NO
- DO YOU USE ALCOHOL? YES NO
- DO YOU USE COCAINE OR OTHER DRUGS? YES NO
- DO YOU WEAR CONTACTS? YES NO
- DO YOU HAVE ANY ALLERGIES? YES NO

  ____

  ____
- HAVE YOU EVER HAD A REACTION TO ANESTHETIC? YES NO

EXPLAIN ABOVE: ____

____

____

PHYSICIAN PHONE ________________

DATE OF LAST EXAM _______________

WOMEN ONLY:

- ARE YOU PREGNANT ________
- ARE YOU NURSING _________
- ARE YOU TAKING BIRTH CONTROL PILLS ____________

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS ABOUT YOURSELF: (*MARK ALL ANSWERS WITH A YES OR NO)*

	YES	NO		YES	NO		YES	NO
HIGH BLOOD PRESSURE	___	___	FREQUENTLY TIRED	___	___	KIDNEY DISEASE	___	___
HEART ATTACK	___	___	ANEMIA	___	___	AIDS/HIV INFECTION	___	___
RHEUMATIC FEVER	___	___	EMPHYSEMA	___	___	STD'S	___	___
SWOLLEN ANKLES	___	___	CANCER	___	___	THYROID PROBLEMS	___	___
FAINTING/SEIZURES	___	___	ARTHRITIS	___	___	HEPATITIS A, B OR C	___	___
ASTHMA	___	___	JOINT REPLACEMENT	___	___	ULCERS	___	___
LOW BLOOD PRESSURE	___	___	CHEST PAINS	___	___	RESPIRATORY PROBLEMS	___	___
EPILEPSY/CONVULSIONS	___	___	SHORT OF BREATH	___	___	OTHER ________________		
LEUKEMIA	___	___	STROKE	___	___	______________________		
DIABETES	___	___	HAY FEVER/ALLERGIES	___	___	______________________		
HEART DISEASE	___	___	TUBERCULOSIS	___	___	______________________		
CARDIAC PACE MAKER	___	___	RADIATION THERAPY	___	___	______________________		
HEART MURMER	___	___	GLAUCOMA	___	___	______________________		
ANGINA	___	___	LIVER DISEASE	___	___			

PATIENT NAME ____

PATIENT DENTAL HISTORY

1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING? ______________________
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS? ______________________
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS? ______________________
4. DO YOU FEEL PAIN IN ANY OF YOUR TEETH? ______________________
5. DO YOU HAVE ANY SORES OR LUMPS IN YOUR MOUTH? ______________________
6. HAVE YOU EVER SUFFERED TRAUMA TO YOUR FACE MOUTH OR JAW? ______________________
7. DOES YOUR JAW EVER CLICK, POP, CRACKLE OR ACHE? ______________________
8. DO YOU HAVE PAIN IN YOUR JAW JOINT, EAR OR SIDE OF THE FACE? ______________________
9. DO YOU HAVE DIFFICULTY OPENING OR CLOSING YOUR MOUTH? ______________________
10. DO YOU HAVE DIFFICULTY CHEWING? ______________________
11. DO YOU HAVE FREQUENT HEADACHES? ______________________
12. DO YOU CLENCH OR GRIND YOUR TEETH? ______________________
13. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY? ______________________
14. HAVE YOU HAD PROBLEMS WITH PREVIOUS DENTAL WORK? ______________________
15. HAVE YOU EVER HAD BRACES? ______________________
16. HOW MANY TIMES A DAY DO YOU BRUSH YOUR TEETH? ______________________
17. HOW OFTEN DO YOU FLOSS? ______________________
18. DO YOU USE A MANUAL BRUSH OR ELECTRIC? ______________________
19. DO YOU USE ANY TYPE OF MOUTH RINSE? ______________________

GOALS FOR YOUR MOUTH, TEETH AND SMILE: ________________________

____

____

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD THAT BE? ____

____

____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been answered accurately. I understand that providing false or incorrect information can be dangerous to my health.

______________________________ ____________________
PATIENT SIGNATURE DATE

____
PRINT NAME

____
DENTIST SIGNATURE

____
_
DATE

____
WITNESS SIGNATURE

____
DATE