New Patient Information Form

ALL SEACOAST
DENTAL ASSOCIATES

Patient's Name _____

Do you have Dental Insurance ? _____ If yes, name of Dental Insurance Company: _____
Do you have Health Insurance ? _____ If yes, name of Health Insurance Company: _____

Dental Health

Why did you seek dental treatment? _____
Are you pleased with the appearance of your smile? _____ Are you interested in our easy, flexible monthly payment Plan? _____

Medical Health

How is your general health? ○ Excellent ○ Good ○ Fair ○ Poor
Who is your physician? Dr. _____ Address _____ Tel. _____

	y | n
Do you have or have you ever had any major medical problems?	○ ○
Have you ever been hospitalized?	○ ○
Are you now, or have you recently been taking any drug or medication?	○ ○
Are you allergic or sensitive to any drugs or medicine (e.g. penicillin, aspirin)?	○ ○
Do you have any difficulty with bleeding or healing from a cut, wound or extraction?	○ ○
Have you ever been told to pre-medicate with an antibiotic prior to dental treatment, due to a medical condition?	○ ○
Do you have or have you ever had any of the following problems?	○ ○

y | n		y | n		y | n		y | n	
○ ○	Rheumatic Fever	○ ○	Allergies	○ ○	Liver Desease	○ ○	Heart Murmur
○ ○	Nervous Disorder	○ ○	Thyroid Problems	○ ○	Heart Disease	○ ○	Angina or Chest Pain
○ ○	High Blood Pressure	○ ○	Stroke	○ ○	Anemia or Blood Disease	○ ○	Lung Disease
○ ○	Asthma	○ ○	Hay Fever	○ ○	Fainting Spells	○ ○	Diabetes
○ ○	Arthritis	○ ○	Cancer	○ ○	Tumors or Growths	○ ○	Kidney Disease
○ ○	Seizure Disorders	○ ○	Sinus Problems	○ ○	Skin Disease	○ ○	Venereal Disease
○ ○	Herpes	○ ○	A.I.D.S.	○ ○	Hepatitis	○ ○	Glaucoma
○ ○	Stomach/Intestinal (Ulcers)	○ ○	Women: Are you pregnant?				

○ ○ None of the above. If yes to any of the above, please explain _____

_____

_____

I certify that the foregoing is true and I give permission for any necessary dental treatment.

Signature _____ **Date** ___/___/_____

Doctor's Notes _____

Medical History Updated By	Date	Medical History Updated By	Date

turn page over

New Patient Information Sheet

Patient's Name (Please Print)	Sex m|f	Date of Birth ____/____/____	Age	Social Security Number / Marital Status s|m|w|d|sep
Street Address ◯ permanent ◯ temporary	City, State, Zip			Home Phone Number
Patient's Employer (If Student Name of School)	Occupation (If student ◯ full ◯ part-time)			How Long Employed/Year at School
Employer Street Address	City, State, Zip			Business Phone Number Extension
Spouse's Name	Date of Birth ____/____/____		Social Security Number	Number of Children and Ages
Spouse's Employer	Occupation (If student full part-time)			How Long Employed/Year at School
Employer Street Address	City, State, Zip			Business Phone Number Extension
Close Relative In Case of Emergency	Relationship			Home Phone Number
Relative's Street Address	City, State, Zip			Cell Phone Number

If The Patient Is A Minor Or Student

Mother's Name	Street Address	Home Phone Number
Mother's Employer	Occupation	How Long Employed
Employer Street Address	City, State, Zip	Business Phone Number Extension
Father's Name	Street Address	Home Phone Number
Father's Employer	Occupation	How Long Employed
Employer Street Address	City, State, Zip	Business Phone Number Extension

I understand that I am financially responsible for any treatment performed, whether or not I have dental insurance

Signature _____ **Date** ___/___/_____

Insurance Information: If you wish us to process

1st or Primary Insurance Carrier	2nd or Secondary Insurance Carrier	Medical Insurance Carrier
Employer's Name	Employer's Name	Employer's Name
Employee/Subscriber Name	Employee/Subscriber Name	Employee/Subscriber Name
Employee/Subscriber Social Security Number	Employee/Subscriber Social Security Number	Employee/Subscriber Social Security Number
Patient's Relationship to Subscriber	Patient's Relationship to Subscriber	Patient's Relationship to Subscriber
Ins. Company Name	Ins. Company Name	Ins. Company Name
Address	Address	Address
Group Plan Name Number	Group Plan Name Number	Group Plan Name Number
Certificate/Policy No. Union/Local No	Certificate/Policy No. Union/Local No	Certificate/Policy No. Union/Local No
Deductibles ◯ yes ◯ no $	Deductibles ◯ yes ◯ no $	Deductibles ◯ yes ◯ no $
Maximum Benefit Per Year $	Maximum Benefit Per Year $	Maximum Benefit Per Year $

I hereby authorize release of information relating to the treatment necessary to process insurance claims.

I hereby authorize payment directly to All Seacoast Dental Associates of the group insurance benefits otherwise payable to me.

Signature _____ **Date** ___/___/_____

Patients are expected to make payment when services are rendered. The investment necessary to complete dental treatment is an estimate based on information from our examination, should additional problems arise, as treatment progresses, this estimate may be revised. This estimate will be honored for a period of three (3) months only.