onsite dental

New Patient Information

About You

First Name: ______________________________ Middle Initial: ________ Last Name: _______________________________

Date of Birth: __________________________ Email: ____

Employee ID #: _____________________ Home Phone: ______________________ Cell Phone: ________________________

Address: ____ City: ______________________ State: _____ Zip: ___________

Employer: ___________________________ Occupation: ______________________ Work Phone: ____________________

Employer's Address: _______________________________ City: ____________________ State: _____ Zip: ___________

Person Responsible for Account if Other than Patient

Name: ___________________________________ Relation to Patient: ____________________ Phone: __________________

Date of Birth: ___________________ Employee ID #: _____________________ Employer: ___________________________

Address: ____ City: ______________________ State: _____ Zip: ___________

Emergency Contact: __________________________ Relation to you: _____________________ Phone: _________________

Address: ______________________________________ City: _______________________ State: ______ Zip: ______________

Spouse Information

Name: ______________________________________ Birth Date: __________________ Employee ID #: __________________

Employer: ____________________________________ Phone: ____________________ Work Phone: ____________________

Insurance Information

Primary Insurance Company: _____________________________ Policy Holder: _____________________________________

Policy Holder's Date of Birth: ___________________ Policy Holder's ID #: _________________ Group #: ________________

Insurance Company Address: _____________________________ City: ___________________ State: ____ Zip: _________

Insurance Company Phone: _____________________________ Insurance Company Fax: _____________________________

Secondary Insurance Company: ______________________________ Policy Holder: ___________________________________

Policy Holder's Date of Birth: _____________________ Policy Holder's ID #: ___________________ Group #: ___________

Insurance Company Address: _____________________________ City: ___________________ State: ____ Zip: __________

Insurance Company Phone: ____________________________ Insurance Company Fax: _______________________________

PAYMENT IS DUE AT TIME OF SERVICE

I understand that I am responsible for payment of services rendered by Onsite Dental, and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the Onsite Dental to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature: ____ Date: ___________________

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

DENTAL HISTORY

What concerns you most? ____________________

Are you having discomfort at this time? ________ What is the discomfort? ____________________

How long since you have been to a dentist? __________ Did you have X-Rays? ______ What else was done? ____________________

Are your teeth sensitive to: heat? _________ cold? __________ sweets? __________ sour? __________ pressure? ____________

Have you ever had your teeth straightened? __________ If so, when? ______________ Did you have traditional braces? _________

How often do you brush your teeth? _______________________ How often do you use dental floss? ________________________

Do you have bleeding gums? ___________ Have you ever had gum treatment? ___________ When? _________________________

Do you grind or clench your teeth? ____________ Do you hear popping or clicking noises when you chew? ____________________

Do you have any pain around either of your ears? ________________ Any swelling or lumps in your mouth? ___________________

Do you have any fear of dental treatment? ____________________

How do you feel about the appearance of your teeth?____________________

____

MEDICAL HISTORY

Are you currently under a Physicians care? ________ Physician's Name ____________________

Physician's Address ____________________ Physician's Phone ____________________

Do you or have you experienced any of the following? (Please circle Y/N)

Y	N	Abnormal Bleeding	Y	N	Colitis	Y	N	Heart Murmur	Y	N	Liver Disease
Y	N	Alcohol Use	Y	N	Congenital Heart Defect	Y	N	Heart Surgery	Y	N	Lupus
Y	N	Anemia	Y	N	Diabetes	Y	N	Hemophilia	Y	N	Pacemaker
Y	N	Artificial Bones/Joints	Y	N	Emphysema	Y	N	Hepatitis	Y	N	Radiation Treatment
Y	N	Artificial Valves	Y	N	Fever Blisters	Y	N	Herpes	Y	N	Seizures
Y	N	Asthma	Y	N	Glaucoma	Y	N	High Blood Pressure	Y	N	Tobacco Use (Smoke/Chew)
Y	N	Cancer	Y	N	Headaches	Y	N	HIV+/AIDS	Y	N	Tuberculosis (TB)
Y	N	Chemotherapy	Y	N	Heart Attack	Y	N	Kidney Problems	Y	N	Venereal Disease

Please list any serious medical condition(s) that you have experienced. ____________________

Are you allergic to any of the following? (Please circle Y/N)

Y	N	Aspirin	Y	N	Erythromycin	Y	N	Sedatives
Y	N	Barbiturates	Y	N	Jewelry/Metals	Y	N	Sulfa Drugs
Y	N	Codeine	Y	N	Latex	Y	N	Tetracycline
Y	N	Dental Anesthetics	Y	N	Penicillin	Y	N	Other

Please list additional drugs/materials that cause allergic reactions: ____________________

Please list any and all medications you are currently taking: ____________________

For Women: Are you taking birth control pills? __________ Are you pregnant? _________ Week #: __________ Are you nursing? ____________

AUTHORIZATION

I affirm that the information I have given is correct to the best of my knowledge. All information herein will be held in the strictest confidence and it is my responsibility to inform Onsite Dental of any changes in my medical status. I authorize dental staff to perform the necessary dental services I may need, including x-rays, photographs, study models, or any aids deemed appropriate to make a thorough diagnosis of my dental needs.

Signature: ____________________ Date: ____________________

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