ADULT NEW PATIENT FORM

Name:_____Sex : _____Date of birth:_____Age:____
Address:_____City:_____ST:___Zip Code:_____
Telephone #'s: Home_____Work_____Cell_____
Responsible Party:_____Relationship to Patient:_____
Address:_____City:_____ST:___Zip Code:_____
How long at this address: _____Previous Address:_____
Telephone #'s: Home_____Work_____Cell_____
SSN:_____Date of Birth:_____Marital Status:_____
Employer:_____Occupation:_____ How Long?_____
Are you using a Medical Spending Account?_____Please advise us at examination appt.
Have we treated other members of your family? If so, names_____
Spouse:_____ Employer_____ Occupation_____
SSN: _____Birthdate:_____
Telephone #'s: Home:_____Work_____Cell_____
Would you like to receive your appointment reminders by: TEXT --- EMAIL --- Home (Circle Choice)

Cell:_____
Email:_____
**********Medical History**********
Are you in good health? Yes__No__
Do you breathe through your mouth ?_____Nose:_____
Have you a history of Trauma to the head and/or neck area? Yes__No__
Have you been involved in a motor vehicle accident?_____When_____
Have you ever had any of the below illnesses? Please circle the ones that apply.

__Rheumatic Fever	__Heart Valve Problems	__Glaucoma	__Anemia
__Diabetes	__Bleeding Tendency	__Hepatitis	__Cancer
__Mononucleosis	__High Blood Pressure	__Epilepsy	__Asthma
__Tuberculosis	__Palpitations	__Allergic to Anesthetics	
__Allergies	__Stomach Ulcers	__Osteoporosis	__Other
__Tested Positive HIV (Aids)			

Have you ever been treated for TMJ Dysfunction?_____When?_____
Do you have pain in your face or jaw? Yes__No__
Does your jaw make a noise? Ie…popping, clicking Yes__No__
Does your jaw get stuck so you cannot open or close? Yes__No__
Do you have frequent headaches____neck pain____ear pain___facial pain_____
Do you have a history of a major condition/Illness? Yes__No__
Please list any Drug Sensitivities or allgeries_____
Please list all Medications you are taking_____
Reason for visit:_____
Whom may we thank for referring you to our office?_____
Medical Doctor_____General Dentist_____

_____
Signature Date

_____
Doctor Signature Date: