HARMONY DENTAL

NEW PATIENT FORM

ABOUT YOU

Patient Name _____ Today's Date _____

Last First M

Preferred name _____

Birthdate _____ Age _____

Social Security# _____

Gender ☐Male ☐Female ☐Other

Mailing Address _____

City State Zip

☐ E-mail Address _____

☐ Home Phone # _____

☐ Work Phone # _____

☐ Cell Phone # _____

Please indicate preferred methods of contact

☐ I authorize text message appointment confirmations and contacts

Referred By _____

Occupation _____

Employer _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Spouse's Name _____

ACCOUNT INFORMATION

Person responsible for account (if different from patient)

Name _____

Relationship _____

Billing Address _____

City State Zip

Social Security # _____

Work Phone # _____

Home Phone # _____

EMERGENCY CONTACT

Name _____

Relationship _____

Phone # _____

Address _____

City State Zip

Who is your primary physician? _____

Physician's Phone # _____

INSURANCE INFORMATION

Do you have dental insurance? ☐Yes ☐No ☐Double Cov

(We will request a copy of your insurance card)

Primary Dental Insurance Carrier _____

ID # _____

☐ Policy holder if different than patient:

Policy holder's name: _____

Relationship _____

Date of Birth _____

Policy Holder's SS# _____

Policy Holder's Employer _____

Secondary Dental or Medical Insurance:

(some services rendered may be covered by your medical insurance)

Carrier: _____

ID # _____

☐ Policy holder if different than patient:

Policy holder's name: _____

Relationship _____

Date of Birth _____

Policy Holder's SS# _____

Policy Holder's Employer _____

☐ I authorize payment directly to In Harmony Dental Care from my Insurance Company.

PAST DENTAL HISTORY

Previous DDS/Clinic _____

Date of last exam/cleaning/treatment _____

Date of last x-rays _____

Reason for transfer _____

Previous treatment (Please check all that apply)

☐orthodontic treatment (braces) ☐oral surgery

☐use of bite guard, retainer, or oral appliance

Existing conditions:

☐Pain ☐Swelling ☐Mobile teeth ☐Bleeding gums ☐Dry mouth

☐Incomplete dental treatment ☐Food impaction problem

☐Head and neck injury ☐ TMJ pain ☐TMJ noises

☐Difficulty opening or closing jaw ☐Dental anxiety

YOUR DENTAL CARE GOALS

Primary reason for today's visit _____

Please highlight services/conditions you would like to discuss:

☐Alleviate pain/infection ☐Cavity prevention

☐Health of gums ☐ Oral cancer screening ☐Wear/TMJ disorders

☐ Teeth realignment (orthodontics) ☐Whitening options

☐ Improve retention of dentures ☐ Teeth replacement options

☐ Smile design ☐Sedation options ☐Smoking cessation

What is most important to you in your dental provider?

_____

_____

HARMONY DENTAL

MEDICAL HISTORY

Please complete medical questionnaire with ✓ in yes or no column

CARDIOVASCULAR	Yes	No	RESPIRATORY	Yes	No
High/ Low blood pressure			Asthma		
Heart disease			Emphysema/ COPD		
History of stroke			Tuberculosis		
Heart attack			Sinus problems		
Angina pectoris (chest pain)			Difficulty breathing		
Heart defect			Congestion		
Heart surgery			Chronic cough		
Artificial heart valve			**NEUROLOGIC**	**Yes**	**No**
Pace maker			Imbalances/ falling		
High cholesterol			Hearing disorder		
Shortness of breath			Numbness/ tingling		
History of fainting /lightheadedness			Epilepsy or seizures		
ENDOCRINE	**Yes**	**No**	**PSYCHIATRIC**	**Yes**	**No**
Diabetes: Type I or II HbA1C:			Depression		
High / Low thyroid			Dementia or memory		
BLOOD	**Yes**	**No**	**ALLERGIES**	**Yes**	**No**
Anemia			Seasonal/ Foods/ Latex/ Other:		
Easy bruising/ bleeding			Penicillin/ Aspirin/ Narcotics/ Sedatives		
Blood transfusion			Anesthetics/ Sulfa/ X-ray Contrast		
IMMUNOCOMPROMISED CONDITION	**Yes**	**No**	**RECREATIONAL DRUG USE**	**Yes**	**No**
Organ transplant			Tobacco Use		
AIDS/ HIV Positive			Alcohol: Social or Regular		
History of cancer			Caffeine		
Kidney disease			Other:		
Liver disease: Cirrhosis/ Hepatitis A/ B/ C			**GASTROINTESTINAL**	**Yes**	**No**
Auto-immune:			Acid Reflux		
MUSCULOSKELETAL	**Yes**	**No**	**REPRODUCTIVE**	**Yes**	**No**
Arthritis: Osteo/ Rheumatoid			Pregnant or Breast Feeding		
Artificial Joints:			Birth Control		
Date of Surgery:			**SLEEP**	**Yes**	**No**
History of TMD:			Excessive sleepiness		✔
Pain/ or Noise in jaw			Tested for sleep apnea, Date:		
Known clenching or grinding			Use CPAP / dental appliance for sleep		
Headaches			**OTHER**	**Yes**	**No**
Parkinson's Disease					

Please list all prescription and OTC medications:_____

_____

_____

_____

ACKNOWLEDGEMENT

We invite you to discuss with us any questions regarding our services. The best dental health services are based on friendly and mutual understanding between provider and patients. Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collection of your unpaid balance. I also authorize the provider to release any information required to process insurance claims; for additional specialist consultation; or in the event I request my records to be transferred to another dental office. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Patient Signature/Guardian:_____ Date:_____

Click to submit via email