Woodlane
Family & Cosmetic Dentistry, P.A.

New Patient Information Form

Please take a few moments to read and complete the following:

Patient Information

First Name _____MI_____ Last Name_____
Preferred Name_____

Birthdate _____ Gender_____ Please Circle One: Married Single Minor Divorced Separated

Address_____
City_____State_____ Zip_____

Home Phone _____ Cell Phone_____ Email _____

Are you a college student? Y / N Name of Employer_____Work Phone_____

Responsible Party

Name of person responsible for this account_____ Relationship Patient_____

Address_____
Phone_____

Birthdate_____ Social Security Number_____
Employer_____

Is this person currently a patient in our office? Y / N

Dental Insurance Information

Plan #1

Policy Holder's Name_____ Birthdate_____ Relationship to Patient_____

Insurance Co. Name_____ Member ID_____
Group Number_____

Plan #2

Policy Holder's Name_____ Birthdate_____ Relationship to Patient _____

Insurance Co. Name_____ Member ID_____
Group Number_____

(Over Please)

Dental History

How often do you brush?_____ How often do you floss?_____Do you use an electric toothbrush? Y / N

When was your last exam and cleaning? _____Have you ever been treated for gum disease? Y / N

Do you have your wisdom teeth? Y / N Have you ever had braces? Y / N Have you whitened your teeth before? Y /N

Current Oral Health

Are you experiencing any of the following symptoms *(please circle)*?

Sensitivity to: COLD SWEETS HEAT BITING/CHEWING

Do any of these apply to you?

LOOSE/SHIFTING TEETH BROKEN FILLING JAW JOINT PAIN NECK PAIN HEADACHE

EARACHE TENDER GUMS DRY MOUTH CLENCHING/GRINDING TEETH SNORE SLEEP APNEA TOBACCO USE

Do you wear a sleep appliance, night guard or a sports guard? Y / N

Notes:

_____
_____

Medical History

Are you taking any medications? Y / N If yes, please list mediation name & why you have been prescribed this below:

_____
_____
_____
_____

List any surgeries you have had and dates:

_____

Do you have any allergies? Y / N If yes, please explain_____

Are you pregnant or nursing? Y / N
Notes_____

Please *circle* any of the following that may apply to you:

AIDS/HIV ANEMIA ARTHRITIS ARTIFICAL HEART VALVE ARTIFICIAL JOINTS ASTHMA ANXIETY/DEPRESSION BLOOD DISEASE BRUISE EASILY CANCER CHEMOTHERAPY COPD DIABETES DRUG/ALCHOHOL ADDICTION FAINTING HIGH/LOW BLOOD PRESSURE HEART CONDITIONS HEPATITIS A,B or C HIGH CHOLESTEROL PACEMAKER/DEFIBRILLATOR KIDNEY DISEASE RHEUMATIC FEVER SCARLET FEVER STROKE STOMACH PROBLEMS THYROID DISEASE TUBERCULOSIS ULCERS VENEREAL DISEASE OTHER:

_____ Notes:

_____

_____

Emergency Contact Name _____ Phone Number_____ Family Physician

_____ Phone Number_____

Signature of patient (or parent/guardian_____
Date_____