New Patient Information

Date: _____

Patient name _____ DOB _____ Status _____
Address Street _____ Unit/Apt# _____ City _____ State_____ Zip_____
Email _____ Home number _____ Cell _____
Employer / School _____ Work / School phone _____
Referred by _____

Insurance Information

Name of Policy holder _____ DOB _____ Relationship _____
Insurance Carrier _____ Subscriber ID / SSN _____
Policy or Group number _____ Employer_____

Secondary Insurance (if any)
Name of Policy holder _____ DOB _____ Relationship _____
Insurance Carrier _____ Subscriber ID / SSN _____
Policy or Group number _____ Employer_____

Emergency Contact

Name _____ Phone number _____ Relationship _____

Are you currently under a physician's care? YES __ NO ___

Physician's Name _____ Phone Number _____

Physician's Address _____

Dental History

Check (✓) if you have any of the following issues:

- ☐ Bleeding Gums
- ☐ Dental Anxiety
- ☐ Gagging
- ☐ Gridding /clenching
- ☐ Gum Sensitivity
- ☐ Jaw pain
- ☐ Mouth Sores
- ☐ Tooth sensitivity
- ☐ Food collection between teeth
- ☐ Chewing on one side of mouth
- ☐ Loose or broken teeth
- ☐ Periodontal treatment

Have you had any serious medical issues associated with any dental treatment? (Anesthesia reaction, Anxiety, ETC.) YES ____ NO ____

IF YES, Please explain _____

Cormier Dental & Associates

New Patient Information

Date: _____

Are you allergic to any medication? YES ___NO ___ If YES, please list

_____

Do you have any allergies? YES ___ NO ___ IF YES, please list

_____

Are you pregnant? YES ___ NO ___

Have you been advised to take antibiotics prior to dental treatment? YES___ NO ___

Have you been hospitalized or had a major operation within the last year? YES ____NO____

IF YES, Please explain _____

_____

PLEASE INDICATE IF YOU HAVE/HAVE HAD ANY OF THE FOLLOWING *MEDICAL* CONDITIONS:

AIDS/HIV POSITIVE…….. ☐	EXCESSIVE THIRST……. ☐	MITRAL VALVE PROLAPSE ….. ☐
ALZHEIMERS DISEASE… ☐	FAINTING/DIZINESS……. ☐	OSTEOPOROSIS……. ☐
AUTO IMMUNE DISORDER. ☐	FREQUENT COUGH……. ☐	PAIN IN JAW JOINTS…… ☐
ANEMIA…….. ☐	FREQUENT DIARRHEA…… ☐	PARATHYROID DISEASE……. ☐
ANGINA…… ☐	FREQUENT HEADACHES… ☐	PSYCHIATRIC DISORDER(S)….. ☐
ARTHRITIS/GOUT…… ☐	GENITAL HERPES…… ☐	RADIATION TREATMENTS…….. ☐
ARTIFICIAL HEART VALVE…… ☐	GLAUCOMA…… ☐	RECENT WEIGHT LOSS……. ☐
ARTIFICIAL JOINT(S)……. ☐	HAY FEVER…… ☐	RENAL DIALYSIS…… ☐
BLADDER DISORDER…….. ☐	HEART ATTACK/FAILURE. ☐	RHEUMATIC FEVER…….. ☐
BLOOD DISEASE…….. ☐	HEART MURMUR…….. ☐	RHEUMATISM…….. ☐
BLOOD TRANSFUSIONS…… ☐	HEART PACEMAKER……. ☐	SCARLET FEVER…… ☐
BREATHING PROBLEM…… ☐	HEART DISEASE…….. ☐	SHINGLES…… ☐
BRUISE EASILY…….. ☐	HEMOPHILIA…….. ☐	SICKLE CELL DISEASE…… ☐
CANCER…….. ☐	HEPATITIS A…….. ☐	SINUS TROUBLE…… ☐
CHEMOTHERAPY…….. ☐	HEPATITIS B OR C ……. ☐	SMOKING…….. ☐
CHEST PAINS…… ☐	HERPES…….. ☐	STOMACH/INTESTINAL DISEASE…… ☐
CONGENITAL HEART DISORDER ☐	HIGH/LOW BLOOD PRESSURE ☐	STROKE…… ☐
CONVULSIONS…… ☐	HIGH CHOLESTEROL…….. ☐	SWELLING OF LIMBS…….. ☐
CORTISONE MEDICINE…… ☐	HIVES OR RASH…… ☐	THYROID DISEASE…… ☐
DEPRESSION…… ☐	HYPOGLYCEMIA…… ☐	TONSILITIS…… ☐
DIABETES…… ☐	IRREGULAR HEARTBEAT… ☐	TUBERCULOSIS…… ☐
DRUG ADDICTION…….. ☐	KIDNEY PROBLEMS……. ☐	TUMORS OR GROWTHS……. ☐
EASILY WINDED…… ☐	LEUKEMIA…… ☐	ULCERS…… ☐
EMPHYSEMA…….. ☐	LIVER DISEASE…… ☐	VENERAL DISEASE…….. ☐
EPILEPSY OR SEIZURES…. ☐	LOW BLOOD PRESSURE… ☐	YELLOW JAUNDICE…….. ☐
EXCESSIVE BLEEDING…… ☐	LUNG DISEASE…… ☐	OTHER…… ☐

IF OTHER, Please explain _____

_____

Cormier Dental & Associates

New Patient Information

Date: _____

Please list all current medications and dosages, including over the counter and herbal

_____

_____

_____

***The following medical information is accurate and current to best of my knowledge. ***

_____ _____

SIGNATURE OF PATIENT/GUARDIAN **DATE**

_____ _____

REVIEWED BY: SIGNATURE **DATE**