The Art of Modern Dentistry

Thomas Volm DDS, Nicholas Sabel DDS, Dennis Hanna DDS

patientcare@newberlindentistry.com

COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

Patient Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell _____

Birthdate _____Age _____ Male ___ Female ___ Social Sec. Number _____

Email Address _____

Marital Status Married ____ Single ____ Divorced ____ Widowed ____ Other____

ACCOUNT INFORMATION

Person Financially Responsible for account _____

Relationship to Patient _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell _____

YOU

Name _____

Occupation _____ Employer _____

Business Address _____

Business Phone # _____ Ext. _____

SPOUSE

Name _____

Occupation _____ Employer _____

Business Address _____

Business Phone # _____ Ext. _____

DENTAL INSURANCE

PRIMARY INSURANCE

Insurance Company Name _____

Group Number _____ Subscriber/Member Number _____

Employee _____ Date of Birth _____

SECONDARY INSURANCE

Insurance Company Name _____

Group Number _____ Subscriber/Member Number _____

Employee _____ Date of Birth _____

GETTING TO KNOW YOU

Is another member of your family or relative a patient at our office? _____ Yes _____ No

Name _____ Relationship _____

How did you hear about us?

_____ Friend
_____ Family member
_____ Insurance company
_____ Facebook
_____ Instagram
_____ Internet Search
_____ Other: _____

Person to contact in an emergency _____

Phone number _____

Address _____

City _____ State _____ Zip _____

Closest Relative not living with you _____

Phone Number _____

Address _____

City _____ State _____ Zip _____

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

Patient Signature _____ Date _____

Parent or Responsible Party _____ Date _____

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New Patient Medical History

Patient Name: _____Date of Birth:_____ Date: _____

Physician Name: _____ Phone: _____

Date of last physical: _____

In the following questions, circle yes or no to respond.

General Health Questions

Yes No Do you have any teeth that are bothering you today? Please explain; _____

_____

Yes No Are you in good health?

Yes No Has there been a change in your health within the last year? If yes, please explain: _____

_____

Yes No Are you currently under the care of a physician? If yes, please explain: _____

_____

Yes No Have you been hospitalized or had a serious illness in the last 5 years? If yes, please explain: _____

_____

Yes No Have you had any serious illness or surgery? If yes, please explain: _____

_____

Yes No Have you ever taken bisphosphonates for osteoporosis? (Fosamax/Boniva)

Yes No Have you ever been told that you need to take premedication prior to dental appointments?

If yes, please explain: _____

Are you allergic to latex or any medications? Please list _____

Do you have or have you had any of the following diseases or conditions:

Yes No Heart Disease/Attack
Yes No Low Blood Pressure
Yes No Irregular heartbeat
Yes No Chest Pain
Yes No Shortness of breath
Yes No Heart Murmur
Yes No Rheumatic fever
Yes No Arthritis
Yes No Asthma
Yes No Seizures/Epilepsy
Yes No Psychiatric treatment
Yes No Cancer
Yes No Radiation treatment
Yes No HPV
Yes No Tuberculosis
Yes No Diabetes
Yes No Artificial Joint
Yes No Alcoholism
Yes No High Cholesterol

Yes No High blood Pressure
Yes No Cardiovascular Disease
Yes No Pacemaker
Yes No Artificial heart valve
Yes No Bleeding Problems
Yes No Stomach Ulcers
Yes No Stroke
Yes No Hepatitis/Liver disease
Yes No Emphysema/lung disease
Yes No Kidney Problems
Yes No Dry mouth
Yes No Sleep apnea/Chronic Snoring
Yes No HIV/AIDS
Yes No Psychiatric disorders
Yes No Osteoporosis
Yes No Thyroid Problem
Yes No Recreational drug use
Yes No Women, are you pregnant/Nursing?

Yes No Have you had abnormal bleeding associated with previous surgery, extraction or trauma?
Yes No Do you have any blood disorder such as anemia or hemophilia?
Yes No Have you had surgery, x-ray or treatment for tumor or other condition of your head or neck?

Yes No Are you taking any prescription or over the counter medication? If so, please list:

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Are you taking any of the following?

Yes No Antibiotics or sulfa drugs
Yes No Anticoagulants
Yes No High blood pressure medication
Yes No Cortisone (steroids)
Yes No Tranquilizers
Yes No Antihistamines
Yes No Aspirin
Yes No Insulin
Yes No Digitalis or drugs for heart concerns
Yes No Nitroglycerines
Yes No Oral Contraceptives or other hormone therapy
Yes No Tobacco use? How much? _____ Type Cigarettes, Vape Chewing? How long? _____

Allergies:

Yes No Local anesthetics
Yes No Penicillin or other antibiotics
Yes No Sulfa Drugs
Yes No Barbiturates, sedatives, or sleeping pills
Yes No Aspirin
Yes No Iodine
Yes No Codeine or other narcotics
Yes No Latex or latex gloves
Yes No Metals

Others: _____

Yes No Have you had any serious trouble associated with any previous dental treatment? If yes, explain: _____
_____

Yes No Are you wearing any removable dental appliances? If yes, what?: _____

Women

Yes No Are you pregnant? If yes, due date? _____

Yes No Are you nursing? _____

Any other conditions or diseases not listed on this form? _____

_____

I certify that I have read and understand the above. I acknowledge that my questions if any about the inquires set forth above have been answered to my satisfaction. I will not hold my dentist or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Dr./Hygienist Signature: _____ Date: _____

Patient/Personal Representative Signature: _____ Date: _____