NOVADONTICS
We do it better.

Today's Date ____________________

PATIENT INFORMATION

Patient Name ____

Preferred Name ____

Address ______________________________________ City ____________________________ Zip ________________

Home Phone ______________ Cell # ________________ Email ____

Sex: M _____ F _____ Age _______ Birth Date __________ Marital Status ____

Social Security # ________________________________ Driver's License # ____________________________________

Employer ____________________________________ Occupation ____

Business Address ____ Business Phone _______________________________________

Name of Spouse ____ Spouse's Occupation ___________________________________

Spouse's Employer ____ Spouse Business Phone _______________________________

Person To Contact in Emergency ______________________ Emergency Contact Phone ____________________________

Please List Any Family Members in Our Care

____

Whom May We Thank For Referring You

____

RESPONSIBLE PARTY

Name of Responsible Party __________________________________ Relationship to Patient ______________________________

Address (if different than above) ______________________________ Phone Number ____

DENTAL INSURANCE INFORMATION

Name of Subscriber ______________________ Relationship To Patient ______________________

Name of Employer______________________ Subscriber's Birth Date______________________

Insurance Co. Name ______________________ Group #______________________

Insurance Co. Phone #______________________ Emergency Contact Phone ______________________

Insurance Co. Address ______________________ Insurance ID # ______________________

Do You Have Additional Insurance Coverage:

____

Physician Name: ______________ Phone: ______________ Last Exam: ______________

Are you under medical treatment now? (please list) ______________________

Have you been hospitalized within the last five years? (please list) ______________________

Are you taking any medication at this time? (please list) ______________________

Have you ever taken Phen-Fen/Redux? ________ Do you use controlled substances? ______ Do you use tobacco or tobacco products in any form? (Please list) ______________________

Women: Are you pregnant or think you may be pregnant? __________ If yes, how many weeks? __________

Are you nursing? ______________ Do you take birth control pills? __________

Please circle if you are allergic to:

Penicillin Latex Codeine Anesthetics Sulfa Drugs Aspirin Other ______________

Please circle any past or present conditions:

Alcohol/Drug Dependency	Artificial Heart Valve Congenital	High Blood Pressure	Hepatitis A
Allergies	Heart Problems Congestive	Low Blood Pressure	Hepatitis B
Anemia	Heart Disease Heart Attack	Glaucoma	Hepatitis C
Angina	Heart Disease	HIV Infection (AIDS)	Kidney Disease
Arthritis	Heart Murmur	Hay Fever	Leukemia
Artificial joints or implants	Heart Pacemaker	Frequent Headaches	Liver Disease
Asthma	Heart Surgery	Ulcers	Seizures /Fainting Respiratory
Cancer	Mitral Valve Prolapse	Lung Disease Tuberculosis	Problems Rheumatic Fever
Diabetes	Stroke	Thyroid Problems	Sinus Problems
Epilepsy			

PATIENT DENTAL HISTORY

Name of Previous Dentist: ______________________________________

Date of Last Exam and X-rays: ______________________________________

Why are you changing dentists? ______________________________________

Do your gums bleed while brushing or flossing? __________________

Are your teeth sensitive to hot or cold liquids/foods? ____________

Do you feel anything unusual in your mouth? ____________________

Do you wear dentures or partials? ____ If yes, placement date? _____

Have you received instructions for the care of your teeth and gums?

____

Do you clench or grind your teeth? ____________________________

Sensitive to sweet or sour liquids/foods?

____

Have you had any head, neck or jaw injuries?

____

Have you had orthodontic treatment?

____

Do you like you, smile? ____________________

Please circle any problems you have experienced in your jaw joint (TMJ):

Clicking Pain Difficulty in opening Difficulty in closing Difficulty in chewing

Is there any other information we should know regarding your medical or dental health? ______________________________

FINANCIAL POLICY

As a courtesy to you we will complete and file insurance forms for your dental treatment. You are responsible for verifying benefits and coverage percentages. The estimated amount the insurance company wilt not cover is due at time of treatment unless prior arrangements are made. Charges for patients without insurance coverage are due at the time of treatment unless prior arrangements are made. Charges not paid within 45 days are subject to a finance charge of 1.5%, per month (18% annual rate).

AUTHORIZATION AND RELEASE

I authorize the release of any information to third party payors and/or health practitioners. I authorize payment from my insurance company to be issued directly to Dr. ___________. I agree to be responsible for payment of full services rendered on my behalf, or my dependent's behalf. I certify I have read and understand the above information and that the information I have provided is accurate.

______________________________________ ___________________________

Patient Signature Date

PATIENT INFORMATION UPDATES: Date: ______________ Signature: _________________________

PATIENT INFORMATION UPDATES: Date: ______________ Signature: _________________________

PATIENT INFORMATION UPDATES: Date: ______________ Signature: _________________________