

**NEW PATIENT INFORMATION FORM (Adult)**

**G. Bradley Gottsegen, D.D.S.**

**PLEASE FILL OUT BOTH SIDES OF THIS SHEET. THANK YOU.**

**PATIENT INFORMATION**

DATE: \_\_\_\_\_

NAME: (last) \_\_\_\_\_ (first) \_\_\_\_\_ (middle) \_\_\_\_\_

NICKNAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE: \_\_\_\_\_

ADDRESS: (street) \_\_\_\_\_ (city) \_\_\_\_\_ (state) \_\_\_\_\_ (zip) \_\_\_\_\_

HOME #: \_\_\_\_\_ WORK #: \_\_\_\_\_ CELL #: \_\_\_\_\_

GENERAL DENTIST: \_\_\_\_\_ PHYSICIAN: \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?: \_\_\_\_\_

WHAT IS YOUR CHIEF CONCERN THAT BRINGS YOU TO OUR OFFICE?: \_\_\_\_\_

**RESPONSIBLE PARTY/CONTACT INFORMATION**

PATIENT'S EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

PATIENT'S SOC. SEC. #: \_\_\_\_\_

**DENTAL INSURANCE INFORMATION**

**PLEASE PROVIDE YOUR INSURANCE CARD TO OUR RECEPTIONIST SO THAT WE MAY MAKE A COPY OF IT FOR OUR RECORDS.**

INSURED'S NAME: \_\_\_\_\_

INSURED'S SOC. SEC. #: \_\_\_\_\_ BIRTHDATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

INSURED'S ADDRESS: \_\_\_\_\_

INSURED'S HOME PHONE #: \_\_\_\_\_ WORK# \_\_\_\_\_ CELL# \_\_\_\_\_

INSURED'S EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

**EMERGENCY INFORMATION**

WHOM SHOULD WE CONTACT IN CASE OF AN EMERGENCY?: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE #: \_\_\_\_\_

**MEDICAL AND DENTAL HISTORY**

PLEASE DESCRIBE ANY IMPORTANT MEDICAL HISTORY OF WHICH WE SHOULD BE AWARE?:

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IS THE PATIENT CURRENTLY UNDER THE CARE OF A PHYSICIAN? IF YES, DESCRIBE: \_\_\_\_\_

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IS THE PATIENT CURRENTLY TAKING ANY MEDICATIONS, INCLUDING PRESCRIPTION AND/OR OVER-THE-COUNTER? \_\_\_\_\_

DOES THE PATIENT HAVE A HISTORY OF HEART MURMUR, PROSTHETIC HEART VALVES, RHEUMATIC FEVER, OR ANY OTHER CONDITION THAT MAY REQUIRE PREMEDICATION WITH ANTIBIOTICS PRIOR TO DENTAL TREATMENT? IF YES, PLEASE DESCRIBE: \_\_\_\_\_

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IS THE PATIENT ALLERGIC TO ANY MEDICATIONS?: WHICH? : \_\_\_\_\_

IS THE PATIENT ALLERGIC TO LATEX?: YES NO

HAVE THE PATIENT'S TONSILS BEEN REMOVED?: YES NO ADENOIDS?: YES NO

IS THE PATIENT EXPERIENCING ANY PAIN, POPPING OR CLICKING SOUNDS, FACIAL PAIN, OR ANY OTHER DYSFUNCTION IN THE AREA OF THE JAW JOINTS (TMJ)? YES NO

**IF YES, PLEASE REQUEST A TMJ QUESTIONNAIRE FROM THE RECEPTIONIST TO ASSIST US WITH OUR EXAMINATION AND DIAGNOSIS OF THE PATIENT.**

HAS THE PATIENT BEEN INVOLVED IN ANY ACCIDENT WHICH HAS CAUSED INJURY TO THE TEETH OR JAWS? IF YES, DESCRIBE, AND GIVE THE DATE OF TRAUMA: \_\_\_\_\_

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PLEASE CIRCLE HISTORY OF ANY OF THE FOLLOWING IMPORTANT HABITS, IF PRESENT:

THUMB/FINGER SUCKING TONGUE THRUST NAIL BITING LIP/CHEEK BITING SMOKING

IS THERE ANY OTHER PERTINENT INFORMATION OF WHICH WE NEED TO BE MADE AWARE OF?

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