



New Patient Information

Finnerty, Wu & Palabrica

Welcome to our practice.

Please take your time to fill out this form completely. The more we learn about you, the better care we are able to provide. We look forward to working with you to maintain a healthy, happy smile.

Patient Information

Patient Number _____

Today's date _____

First name _____ Middle initial _____ Last name _____

I prefer to be called (nickname, etc.) _____ Male Female

Address _____ City _____ State _____ ZIP _____

Date of birth _____ Social security no. _____

Home phone (____) _____ - _____ Work phone (____) _____ - _____ Cell phone (____) _____ - _____

Primary contact number (please check one) Home Work Cell Best time to call _____

Fax (____) _____ - _____ E-mail _____ Driver's license no. _____

Employer _____ Occupation _____

Spouse's name _____ Spouse's employer _____

Whom may we thank for referring you? _____

If the patient is a child

School _____ School phone (____) _____ - _____ Grade _____

Dental History

Reason for today's visit _____

Are you currently in pain? Yes No
If so, please describe: _____

Do you have any dental problems now? Yes No
If so, please describe: _____

Have you ever had trouble with a previous dental treatment? Yes No
If so, please describe: _____

Level of anxiety about seeing the dentist: (least) 1 2 3 4 5 (most)

Date of last dental exam _____ Date of last cleaning _____ Date of last full mouth X-rays _____

Procedure(s) done at last dental visit _____

Previous dentist's name _____

City _____ State _____ Phone (____) _____ - _____

Why are you changing dentists? _____

How often do you have dental examinations? _____ How often do you brush your teeth? _____

How often do you floss? _____ What type of bristles do you use? Hard Medium Soft

What other dental aids do you use? (Electric toothbrush, toothpick, etc.) _____

Do you require antibiotics before dental treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have frequent headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do your gums ever bleed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you clench or grind your teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you noticed any mouth odors or bad tastes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are your teeth sensitive to heat/cold?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you bite your lips or cheeks frequently?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you still have your wisdom teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No



Have you ever had:

- Periodontal disease/gum treatment
Orthodontics treatment
Oral surgery
A bite plate or mouth guard
Discomfort in your jaw joint (TMJ/TMD)
Your teeth ground or bite adjusted
Serious injury to the mouth or head

If yes to any of the previous questions, please describe

Is there anything else about your past dental treatment(s) that you would like us to know?

Medical History

Have you been hospitalized or under the care of a medical doctor during the past 2 years?

If yes, for what?

Hospital or Physician's name Phone

Hospital or Physician's City State

Have you taken any medications or drugs in the past two years?

Are you currently taking any medications or drugs? (including regular doses of aspirin or over-the-counter medicines)

If yes, please explain

Have you ever taken Fen-Phen?

If so, how long ago?

Have you been to the doctor to check for heart problems?

If so, what are the problems?

Do you use tobacco? Do you use alcohol or any other controlled substance?

Women only:

Are you pregnant or think you may be pregnant? Are you nursing?

Are you taking birth control pills?

Indicate which of the following you have had or have at present:

- AIDS/HIV, Alcohol/Drug Abuse, Allergies or Hives, Anemia, Arthritis/Rheumatism, Artificial Heart Valve, Artificial Bones/Joints, Asthma, Blood Disease, Blood Transfusion, Bruise Easily, Cancer/Chemotherapy, Chest Pain, Cold Sores/Herpes, Colitis, Contact Lenses, Cortisone Medicine, Diabetes, Diet (Special/Restricted), Difficulty Breathing, Emphysema, Epilepsy or Seizures, Fainting or Dizzy Spells, Frequent Headaches, Glaucoma, Hay Fever, Heart (Surgery, Disease, Attack), Heart Pacemaker, Heart Murmur, Hemophilia/Abnormal Bleeding, Hepatitis A B C (circle), High or Low Blood Pressure, Hospitalized for Any Reason, Jaundice, Kidney Trouble, Liver Disease, Lupus, Mitral Valve Prolapse, Nervousness/Anxiety, Neurological Disorders, Psychiatric/Psychological Care, Radiation Therapy, Rheumatic/Scarlet Fever, Shingles/Chicken Pox, Sickle Cell Disease/Traits, Sinus Trouble, Snoring/Sleep Apnea, Stomach Problems/ Ulcers, Stroke, Swollen Ankles, Thyroid Problems, Tuberculosis (TB), Tumors, Venereal Disease/STD

Please list any serious medical condition(s) that you have ever had not listed above:

Are you aware of having an allergic (or adverse) reaction to any of the following:

- Aspirin, Codeine, Anesthetics (i.e. Novocaine), Erythromycin, Iodine, Jewelry/Metals, Latex, Penicillin or Other Antibiotics, Sedatives, Sulfa Drugs, Tetracycline, Other

Patient signature



Dental Insurance

Primary Carrier

Insurance co. name Insurance co. phone
Address (Street, City, State, ZIP)
Group no. (Plan or Policy no.) Insured's I.D. no.
Insured's name Relationship to patient
Date of birth Insured's social security no.
Insured's employer name Is insured a patient in our practice? Yes No

Secondary Carrier

Insurance co. name Insurance co. phone
Address (Street, City, State, ZIP)
Group no. (Plan or Policy no.) Insured's I.D. no.
Insured's name Relationship to patient
Date of birth Insured's social security no.
Insured's employer name Is insured a patient in our practice? Yes No

Person Financially Responsible for Account

Name Relationship to patient
Social security no. Phone () -
Driver's license no. Date of birth
Address (Street, City, State, ZIP)
Employer Work phone () -
Preferred payment method: Cash Credit Card
Visa/MC/AMEX no. Exp. date
If patient is a minor, name of parent or legal guardian and relationship
Is this parent or legal guardian currently a patient in our office? Yes No

Payment is due in full at the time of treatment

(Unless prior arrangements have been approved)

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective healthcare provider or agency that may release such information to you. I will notify the dentist of any changes in my health or medication.

Signature Date

Person to contact in case of emergency

Name Relationship
City State Cell phone
Home phone Work phone

OFFICE USE ONLY

I VERBALLY REVIEWED THE MEDICAL / DENTAL INFORMATION ABOVE WITH THE PATIENT NAMED HEREIN.

Date Initials