NewLeaf DENTAL CARE

# WELCOME

**Thank you for selecting our dental team! We will always offer you the most up to date dental care available. To help us meet your dental needs, please complete the following information and bring it to your appointment. Thank you for your cooperation.**

**Personal Information**

Name________________________________________ ☐ Male ☐ Female ☐ Single ☐ Married

Do you use your legal name or how do you wish to be addressed? ____________________________________

Address____________________________________________ City/State/Zip______________________________

SSN ________________________ DOB: (M/D/YR) ____/____/_____

Name of spouse______________________

Occupation_____________________ Employer_______________________

Who may we thank for referring you to our office?

_______________________________________________________________________________________________

**Responsible Party**

Name ________________________________________ Relation to patient_______________________________

DOB: (M/D/YR) ____/____/_____ SSN ___________________

IT IS UNDERSTOOD THAT NEW LEAF DENTAL CARE WILL NOT TREAT A PERSON UNDER THE AGE OF 18 WITH OUT THE INFORMED CONSENT OF THE PARENT OR GUARDIAN.

Signature of Parent/

Guardian___________________________________________________________________________________

**How may we contact you?**

Home Phone ________________ Work Phone ________________ Ext._______Cellular Phone________________

Email__________________________ Where do you prefer to receive calls? ☐Home ☐Work ☐Cell

NewLeaf DENTAL CARE

# Insurance Information

Policy Holder's Name_______________________________________________________

SSN _______________________ DOB: (M/D/YR) _____/_____/_____

Name of Employer ____________________________________________________________

Name of Insurance Company ___________________________________________________

Address ______________________________________________________________________

City/State/Zip __________________________ Phone # _____________________________

Group # ____________________ Insurance ID# (if not SSN)__________________________

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SSN_______________________ DOB: (M/D/YR) _____/_____/_____

Name of Employer ____________________________________________________________

Name of Insurance Company ___________________________________________________

Address ______________________________________________________________________

City/State/Zip __________________________ Phone # _____________________________

Group # ____________________ Insurance ID# (if not SSN)__________________________

**Patient Name:** ____________________________ **Date of Birth:** _______________________

**Social Security Number:** ___________________

If you have had dental treatment recommended in the past and did not proceed, what factors prevented you from scheduling? (Here or elsewhere)

__Cost
__Fear of Pain
__No time
__No insurance
__Didn't hurt/Didn't think I needed treatment
__Other (please explain) _______________________________

# HEALTH HISTORY

Physician's Name: _____________________________ Date of last medical exam: ____________________

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

__AIDS
__Anemia
__Arthritis
__Artificial Heart Valves
__Artificial Joints
__Asthma
__Back Problems
__Cancer, Tumor, Malignancy
__Chemical Dependency
__Chemotherapy
__Circulatory Problems
__Cortisone Treatments
__Cough up Blood
__Congenital Heart Disorder
__Cough, Persistent
__Diabetes
__Epilepsy, Seizures
__Fainting, Dizziness
__Glaucoma
__Headaches
__Heart Attack
__Heart Murmur
__Hepatitis , Type _____
__Herpes
__High Blood Pressure
__HIV Positive
__Hospitalization
__Immune Disorder
__Jaundice
__Kidney Disease
__Liver Disease
__Major Surgery, Type _________________
__Mitral Valve Prolapse
__Nervous problems
__Pacemaker
__Pain in Jaw Joint
__Prolonged Bleeding Disorder
__Psychiatric Care
__Radiation Treatment
__Respiratory Disease
__Rheumatic Fever
__Scarlet Fever
__Shortness of Breath
__Sinus Trouble
__Skin Rash
__Stroke
__Swelling of Feet or Ankles
__Taking Fen-Phen or Redux?
__Thyroid Problems
__Tobacco Habit, Type ___________ How much ___________
__Tonsillitis, Lung Disease
__Tuberculosis
__Ulcer
__Venereal Disease
__Are You Pregnant? Due Date __________

## Medications

List medications you are currently taking:
(Include oral contraceptives and alternative medicines)

__________________________________________
__________________________________________

## Allergies

__Aspirin
__Barbiturates
__Codeine
__Latex
__Other:_______________________________________
__Local Anesthetic
__Penicillin
__Sulfa

## Pre-medication

Do you normally take an antibiotic prior to dental treatment? ___ yes ___ no

The above information is accurate and complete to the best of my knowledge. I will not hold the dentist or any member of New Leaf Dental Care responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _______________________________________ Date: ____________________________________

## Authorization

I authorize my insurance company to pay New Leaf Dental Care all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether paid by my insurance or not.

Signature ________________________________ Date ________________________________

I consent to the use of my pictures for educational purposes and publication by New Leaf Dental Care.

Signature _______________________________________ Date: ____________________________________

**Payment is due in full at time of treatment unless prior arrangements have been made.**