

Welcome

Thank you for choosing Newton Cosmetic Dentistry!
To help us perfect your smile with the best dental care possible, please fill out this form completely in ink. If you have any questions, we'll be happy to help.

Patient Information *(Confidential)*

Date: _____

Patient Name: _____
(Last) (First) (Middle) (Home Phone #)

Address: _____
City State Zip

Place of Employment: _____ **Occupation:** _____

Business Address: _____
City State Zip Business Phone #

Date of Birth: _____ **SS#:** _____ **Male:** _____ **Female:** _____

Height: Ft ___ In ___ **Weight #** _____ **Marital Status:** Single _____ Married _____ Divorced _____ Widowed _____

Hobbies: _____

Spouse Name: _____ **Date of Birth:** _____

Place of Employment: _____ **Occupation:** _____

Business Address: _____

Person responsible for the account: _____
Add address if different from above

Whom may we thank for referring you to our office? _____

Has any member of your family been to our office previously? Y ___ N ___ Relationship: _____

Why did you choose Newton Cosmetic Dentistry? _____

Please complete the following confidential information regarding DENTAL insurance.

Primary Carrier Insurance Company: _____

Mailing Address: _____

Insured's Name: _____ **SS#:** _____ **Group #:** _____

Secondary Carrier Insurance Company: _____

Mailing Address: _____

Insured's Name: _____ **SS#:** _____ **Group #:** _____

Dental History

Dental Health: Excellent Good Fair Poor

What priority do you give your teeth (10 being the highest)? 1 2 3 4 5 6 7 8 9 10

Reason for today's visit? _____

Former Dentist: _____

City/State: _____

Date of last dental visit: _____

Date of last dental X-rays: _____

Mark "Y" or "N" if you have had any of the following:

Bad Breath Y N

Bleeding Gums Y N

Blisters on lips or mouth Y N

Burning sensation on tongue Y N

Chew on one side of mouth Y N

Cigarette, pipe, or cigar smoking Y N

Clicking or popping jaw Y N

Dry mouth Y N

Fingernail biting Y N

Food collection between teeth Y N

Frequent head aches Y N

Clench or grind your teeth Y N

Gums swollen or tender Y N

Lip or cheek biting Y N

Loose teeth or broken fillings Y N

Mouth breathing Y N

Mouth pain, brushing Y N

Orthodontic treatment Y N

Pain around ear Y N

Periodontal treatment Y N

Sensitivity to cold Y N

Sensitivity to heat Y N

Sensitivity to sweets Y N

Sensitivity when biting Y N

Sores or growths in your mouth Y N

How often do you floss? _____

How often do you brush? _____

Do you like your smile? _____

Have you had any head, neck or jaw injuries? _____

Health History

Medical Health: Excellent Good Fair Poor

Physician's Name: _____ Office Phone #: _____

Last complete physical? _____ Are you under a doctor's care now? _____ If yes, for what reason? _____

Mark "Y" or "N" to indicate if you have had any of the following:

Angina	<input type="checkbox"/> Y <input type="checkbox"/> N	Epilepsy/Seizures	<input type="checkbox"/> Y <input type="checkbox"/> N	Rheumatic Fever	<input type="checkbox"/> Y <input type="checkbox"/> N
AIDS	<input type="checkbox"/> Y <input type="checkbox"/> N	Fainting or dizziness	<input type="checkbox"/> Y <input type="checkbox"/> N	Scarlet Fever	<input type="checkbox"/> Y <input type="checkbox"/> N
Allergies/Hay Fever	<input type="checkbox"/> Y <input type="checkbox"/> N	Glaucoma	<input type="checkbox"/> Y <input type="checkbox"/> N	Shortness of Breath	<input type="checkbox"/> Y <input type="checkbox"/> N
Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N	Gout	<input type="checkbox"/> Y <input type="checkbox"/> N	Sinus Trouble	<input type="checkbox"/> Y <input type="checkbox"/> N
Alzheimer's Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Headaches	<input type="checkbox"/> Y <input type="checkbox"/> N	Skin Rash	<input type="checkbox"/> Y <input type="checkbox"/> N
Artificial Heart Valves	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart murmur	<input type="checkbox"/> Y <input type="checkbox"/> N	Special Diet	<input type="checkbox"/> Y <input type="checkbox"/> N
Artificial joints	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart Problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Stroke	<input type="checkbox"/> Y <input type="checkbox"/> N
Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart Surgery	<input type="checkbox"/> Y <input type="checkbox"/> N	Swelling of feet	<input type="checkbox"/> Y <input type="checkbox"/> N
Back problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Hepatitis	<input type="checkbox"/> Y <input type="checkbox"/> N	or ankles	<input type="checkbox"/> Y <input type="checkbox"/> N
Bleeding abnormally,		Type _____		Thyroid Problems	<input type="checkbox"/> Y <input type="checkbox"/> N
with extractions or surgery	<input type="checkbox"/> Y <input type="checkbox"/> N	Herpes	<input type="checkbox"/> Y <input type="checkbox"/> N	Tonsillitis	<input type="checkbox"/> Y <input type="checkbox"/> N
Blood Disease, Leukemia	<input type="checkbox"/> Y <input type="checkbox"/> N	High Blood pressure	<input type="checkbox"/> Y <input type="checkbox"/> N	Tuberculosis	<input type="checkbox"/> Y <input type="checkbox"/> N
Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N	HIV Positive	<input type="checkbox"/> Y <input type="checkbox"/> N	Tumor or growth	<input type="checkbox"/> Y <input type="checkbox"/> N
Chemical Dependency	<input type="checkbox"/> Y <input type="checkbox"/> N	Hypoglycemia	<input type="checkbox"/> Y <input type="checkbox"/> N	on head or neck	<input type="checkbox"/> Y <input type="checkbox"/> N
Chest Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Jaundice	<input type="checkbox"/> Y <input type="checkbox"/> N	Ulcer	<input type="checkbox"/> Y <input type="checkbox"/> N
Chemotherapy	<input type="checkbox"/> Y <input type="checkbox"/> N	Jaw Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Venereal Disease	<input type="checkbox"/> Y <input type="checkbox"/> N
Congenital Heart Lesions	<input type="checkbox"/> Y <input type="checkbox"/> N	Kidney Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Weight Loss,	<input type="checkbox"/> Y <input type="checkbox"/> N
Cough, persistent or bloody	<input type="checkbox"/> Y <input type="checkbox"/> N	Liver Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	unexplained	<input type="checkbox"/> Y <input type="checkbox"/> N
Diabetes/Family history	<input type="checkbox"/> Y <input type="checkbox"/> N	Low Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N		
Emphysema	<input type="checkbox"/> Y <input type="checkbox"/> N	Mitral Valve Prolapse	<input type="checkbox"/> Y <input type="checkbox"/> N		
Do you wear contact lenses?	<input type="checkbox"/> Y <input type="checkbox"/> N	Nervous Problems	<input type="checkbox"/> Y <input type="checkbox"/> N		
Parathyroid Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Pacemaker	<input type="checkbox"/> Y <input type="checkbox"/> N		
Prostate Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Women:	<input type="checkbox"/> Y <input type="checkbox"/> N		
Psychiatric Care	<input type="checkbox"/> Y <input type="checkbox"/> N	Are you Pregnant?	<input type="checkbox"/> Y <input type="checkbox"/> N		
Radiation Treatment	<input type="checkbox"/> Y <input type="checkbox"/> N	Due Date? _____			
Respiratory Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Are you Nursing?	<input type="checkbox"/> Y <input type="checkbox"/> N		

Do you use tobacco? Y N

Do you use controlled substances? Y N

Are you wearing contact lenses? Y N

Have you ever been hospitalized for any surgical operation or serious illness within the last five years? Y N

If yes, please explain: _____

Medications	Allergies												
<p>List Medications you are currently taking:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Pharmacy Name: _____</p> <p>Phone: _____</p>	<table border="0"> <tr> <td><input type="checkbox"/> Aspirin</td> <td><input type="checkbox"/> Local Anesthetic</td> </tr> <tr> <td><input type="checkbox"/> Barbiturates (Sleeping Pills)</td> <td><input type="checkbox"/> Penicillin</td> </tr> <tr> <td><input type="checkbox"/> Codeine</td> <td><input type="checkbox"/> Sulfa</td> </tr> <tr> <td><input type="checkbox"/> Iodine</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td><input type="checkbox"/> Latex</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Metals (nickelate)</td> <td>_____</td> </tr> </table>	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Local Anesthetic	<input type="checkbox"/> Barbiturates (Sleeping Pills)	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa	<input type="checkbox"/> Iodine	<input type="checkbox"/> Other _____	<input type="checkbox"/> Latex	_____	<input type="checkbox"/> Metals (nickelate)	_____
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Authorization and Release

I certify that I have read and understood the above information to the best of my knowledge. The above questions have been accurately answered, as providing incorrect information could be dangerous to my health. I authorize Newton Cosmetic Dentistry to release records of any treatment or examination rendered to me or my child to third-party payors and/or health practitioners. I authorize and request my insurance company pay directly to Newton Cosmetic Dentistry. I understand that my dental insurance carrier may pay less than the actual bought services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature: _____

Date: _____