Impressions DENTAL

NEW PATIENT FORMS

Patient Information

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Name _____ Gender ☐ M ☐ F DOB _____

Address _____ Age _____

SS# _____ City _____ St _____ Zip _____

DL# _____ Phone _____ Email _____

Have you ever been a patient of our practice? ☐ Yes ☐ No Current Primary Physician _____

Has a family member been a patient of our practice? ☐ Yes ☐ No Preferred Pharmacy _____

Emergency contact _____ Telephone _____ Relation _____

Responsible Party

☐ Self (if self, skip this section) ☐ Spouse ☐ Father ☐ Mother ☐ Other

Name _____ SS# _____ DL# _____ DOB _____

Address _____ City _____ St _____ Zip _____

Telephone _____ Email _____ Employer _____

Primary Dental Insurance

Employer _____

Member ID# _____

Group# _____

Group Name _____

Insured Party _____

Relation _____

Gender M ☐ F ☐ Birthdate _____

SS# _____

Address _____

City_____ St_____ Zip_____

Telephone _____

Secondary Dental Insurance

Employer _____

Member ID# _____

Group# _____

Group Name _____

Insured Party _____

Relation _____

Gender M ☐ F ☐ Birthdate _____

SS# _____

Address _____

City_____ St_____ Zip_____

Telephone _____

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Dental Information

Reason for today's visit _____

Are you in pain? ☐ Yes ☐ No When did the pain begin? _____

Please indicate any of the following problems by checking the corresponding box:

☐ Missing teeth	☐ Lost/broken filling(s)	☐ Stained teeth	☐ Difficulty closing jaw
☐ Red, swollen, or bleeding gums	☐ Teeth grinding/clenching	☐ Jaw discomfort	☐ Difficulty opening jaw
☐ Crooked teeth	☐ A removable dental appliance	☐ Bad breath	☐ Loose/shifting teeth
☐ Blisters/sores in or around mouth	☐ Broken/chipped tooth	☐ Teeth sensitive to bite pressure	☐ Toothache
☐ Swelling/lumps in mouth	☐ Recent infections or sore throat	☐ Teeth sensitive to cold	☐ Teeth sensitive to hot

☐ Other _____

Medical History

Are you in good health? ☐ Yes ☐ No

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ Yes ☐ No

Have you had any illness, operation, or been hospitalized in the past five years? ☐ Yes ☐ No

Please indicate any of the following problems by checking the corresponding box:

☐ Rheumatic Fever	☐ Asthma	☐ Bleeding tendency	☐ Sexually Transmitted Disease (STD)
☐ High blood pressure	☐ Mental health problems	☐ Blood transfusion	☐ COVID-19
☐ Low blood pressure	☐ Immunodeficiency	☐ Blood disorder	☐ Contagious disease
☐ Mitral valve prolapse	☐ Delayed healing	☐ Bruise easily	☐ Arthritis/Joint disease
☐ Heart murmur	☐ Hay fever/sinus problems	☐ Eye disease/glaucoma	☐ Prosthetic implant
☐ Chest pain/Angina	☐ Snoring	☐ Jaundice/Liver disease	☐ Joint replacement
☐ Heart attack(s)	☐ Sleep apnea/CPAP	☐ Hepatitis	☐ Osteoporosis/Osteopenia
☐ Irregular heartbeat	☐ Respiratory problems	☐ Fainting spells	☐ Osteonecrosis
☐ Cardiac pacemaker	☐ Tuberculosis	☐ Convulsions/Epilepsy	☐ Stomach ulcers/Acid Reflux
☐ Heart surgery	☐ Emphysema	☐ Stroke	☐ GI troubles/IBS/Colitis
☐ Damaged heart valves	☐ Use chewing tobacco	☐ Kidney trouble	☐ Tumor or growth
☐ Pneumonia/Bronchitis/ Chronic cough	☐ Trouble climbing 1-2 flights of stairs	☐ Diabetes	☐ Cancer/Radiation/Chemo
☐ Chronic fatigue/Night sweats	☐ Abnormal bleeding	☐ Low blood sugar	☐ Dialysis?
☐ Smoke or vape? How much?		☐ Other:	This is a test to see if this line wraps. I hope this works because I don't know if it

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Are you now taking any of the following:

☐ Pain killers (including aspirin) ☐ Insulin ☐ Stimulants ☐ Antidepressants ☐ Blood thinners (Coumadin, Aspirin, Eliquis, Xarelto)

☐ Bone Density Meds, RANKL inhibitors or bisphosphonates (Denosumab, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast, Prolia, Xgeva or Evista in the past 15 years)

For women only. Please mark all that apply.

☐ Is there a possibility of pregnancy? Due Date _____

☐ Are you nursing? ☐ Are you taking birth control pills?

Medications and Allergies

Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products):

Medication	Dosage	Frequency

Are you allergic to, or had a reaction to:

☐ Penicillin ☐ Sulfa drugs ☐ Local anesthetic (numbing med) ☐ Amoxicillin

☐ Sodium pentothal / Valium ☐ Aspirin ☐ Codeine or other narcotics ☐ Latex

☐ Soy ☐ Eggs/yolk ☐ Sulfites

Please list any other medication or antibiotic you are allergic to:

Medication/Antibiotic Name	Briefly describe the reaction: