BOND
FAMILY & IMPLANT DENTISTRY

New Patient Information

Welcome to our practice! Thank you so much for choosing us as your oral health care providers. Please help us gather some information about you to serve you better. **Date ___/___/_____**

Patient Name _____ Preferred Name _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child Age _____

Spouse or Parent Name _____ Birthdate ____/____/_____

Home Address _____
Street City/State Zip

Emergency Contact _____ Em. Contact Phone (_____) _____-_____

We use text messaging and email for appointment reminders.

Cell Phone (_____) _____-_____ Work Phone (_____) _____-_____ Home (if not cell) (____) _____-_____

Email address _____

Employer Name _____Position _____ How long there? _____

Responsible Party: Social Security # _____-____-_____ Driver's License # _____

Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Phone (_____) _____-_____
Street City/State Zip

Employer _____ Work Phone (_____) _____-_____

Insurance Information (please let us know if you have more than one insurance plan)

Subscriber Name _____ Relationship to Patient _____ Birthdate ___/___/____

Name of Employer _____ Work Phone (_____) _____-_____ SS# _____-_____-_____

Insurance Company _____ Plan # _____ Group # _____

Insurance Address _____ Phone (_____) _____-_____
Street City/State Zip

Referral Information – Help us reward who referred you!

Can we thank someone for referring you?	**Or did you find us on your own?**
Family Member _____	__Looked us up on Google
Coworker _____	__Found our Website through an ad
Friend _____	__Found us through your insurance company

What is the main reason for your dental visit with us? _____

_____

Date of last dental visit _____ Date of last dental x-rays taken _____

Are you interested in sedation dentistry? ☐ Yes ☐ No In whitening your teeth? ☐ Yes ☐ No

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Do you prefer to use Nitrous Oxide (laughing gas) during dental treatment? ☐ Yes ☐ No

Why did you leave your previous dentist? _____

If you could change your smile, what would you change? _____

What is your main priority with your teeth? _____

Please list any painful areas in your mouth _____

Please list sensitive areas in your mouth _____

Please list any previous complications with dental treatment _____

Do you have any missing teeth you would like to replace? _____

Have you experienced pain or clicking in your jaw, or difficulty in chewing or opening? ☐ Yes ☐ No

Do you clench or grind your teeth, or wake up with soreness around your face? ☐ Yes ☐ No

Has gum therapy or a "deep cleaning" been recommended for you in the past? ☐ Yes ☐ No

Do your gums bleed while brushing or flossing? ☐ Yes ☐ No

Please indicate which of the following applies to you either currently or in the past.

Kidney Disease or Renal Dialysis	☐	Arthritis	☐
HIV infection/AIDS	☐	Thyroid Disease	☐
Asthma	☐	Stroke	☐
Diabetes	☐	Blood Disorder, Abnormal Bleeding	☐
Liver Disease	☐	Radiation or Chemotherapy Treatment	☐
COPD or other Lung Disease	☐	Glaucoma	☐
High Blood Pressure/Hypertension	☐	Fainting, Epilepsy or Seizures	☐
Artificial Heart Valve or Heart Transplant	☐	Cancer	☐
Congenital Heart Disease, Shunts or Stents	☐	Psychiatric Therapy	☐
Rheumatic Fever, Bacterial Endocarditis	☐	Tuberculosis	☐
Heart Attack, Heart Disease, Angina	☐	Hepatitis, Any Form	☐
Pacemaker	☐	Other Conditions _____	

Please indicate if you take any of the following medications:

Pre-medication before dental treatment? Since what year? _____	No	Yes	Biaxin® (clarithromycin)	No	Yes
Antacids?	No	Yes	Cardizem® (diltiazem) or Calan, Isoptin® (Verapamil)?	No	Yes
St. John's Wort or Kava-Kava?	No	Yes	Barbiturates (any)	No	Yes
Dilantin® or Tegretol®	No	Yes	Diflucan® (fluconazole) or Sporonox® (itraconazole)	No	Yes
Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®, RECLAST) or PROLIA? If so, when did the treatment begin? When did the treatment end?				No	Yes
Do you consume grapefruit juice, grapefruits or grapefruit extract?				No	Yes

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Please list any medications you are currently taking:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____

Please list any dietary or herbal supplements you are taking:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Women: Are you pregnant?	No	Yes	Due Date _____
If no, are you planning a pregnancy in the near future?	No	Yes	
Are you a nursing mother?	No	Yes	
Are you taking birth control pills?	No	Yes	

Are you allergic or have you had a reaction to:

Local anesthetics or epinephrine	No	Yes	
Penicillin or other antibiotics	No	Yes	Specify: _____
Aspirin, Ibuprofen or Tylenol®	No	Yes	
Codeine, Valium®, Hydrocodone, Oxycodone or other sedatives	No	Yes	
Latex Rubber or Metals	No	Yes	

Other (please specify)_____

Tobacco, Alcohol, Drugs

Do you use tobacco? If yes, circle type: smoke chew How much per day? For how long?	No
Do you consume alcohol? If yes, approximately how many alcoholic beverages per week?	No
Do you use any recreational or mood-altering drugs?	No

Please explain if you are currently under medical treatment _____

_____

Physician's Name _____ Phone (_____) _____-_____

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. You have my permission to ask my health care provider or agency to release additional information to you. I will notify the doctor of changes in my health and medication. I authorize the dentist to release any information including any diagnosis and records of any treatment or examination rendered to me or my child to third party payors and/or health practitioners.

_____ _____ _____

Patient (Print Name) Patient Signature Date