Sandpiper Dental

New Patient Information

Patient's name: ______________________________ Preferred name ______________
(First) (Last) (MI)
Birth Date: ______________ Social Security number: ______________
Home phone: ______________ Cell phone: ______________ Work phone: ______________
Mailing address: ______________________________ Driver's License #: ______________
City ______________ State ______________ Zip ______________
❑ Child ❑ Married ❑ Single ❑ Widowed ❑ Other
Email Address______________________________
Whom may we thank for referring you to our office?______________________________

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ No Dental Insurance

Primary Policy Holders Name ______________________________ Birth Date______________
Dental Insurance Co: ______________________________ Group number: ______________
Subscriber ID: ______________ Social Security Number______________

Covered by dual insurance? ❑ Yes ❑ No Policy Holders Name______________________________
Dental insurance company ______________________________ Group number ______________
Policy Holders birthday ______________ Subscriber ID ______________

Dental History

Previous Treating Dentist Name: ______________________________
Approximately how long has it been since your last dental visit?______________________________

Are you happy with the appearance of your teeth?	Yes	No
Have you ever had Periodontal (gum) Surgery or Treatment?	Yes	No
Have you had any Orthodontic work (braces)?	Yes	No
Have you ever had any reaction to dental anesethic (novocain) or Nitrous Oxide?	Yes	No
Are you in any dental pain right now?	Yes	No

Do you have any specific concerns about your Dental Health?
(Broken/missing teeth, teeth causing you pain? want whiter teeth? want straighter teeth?)
Please explain______________________________

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OVER

Sandpiper Dental

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check all that apply)

- ☐ Premed Needed Prior to Dental Treatment
- ☐ Heart ailment or angina
- ☐ Heart murmur, mitral valve prolapse, heart defect
- ☐ Rheumatic fever or rheumatic heart disease
- ☐ Artificial joint or valve
- ☐ High or low blood pressure
- ☐ Pacemaker
- ☐ Tuberculosis or other lung problems
- ☐ Kidney disease
- ☐ Hepatitis or other liver disease
- ☐ Blood transfusion
- ☐ Cancer or tumor
- ☐ Radiation/Chemotherapy Treatment
- ☐ Diabetes
- ☐ Neurologic condition
- ☐ Epilepsy, seizures, or fainting spells
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Inflammatory Diseases (MS, Lupus)
- ☐ Herpes or cold sores
- ☐ Osteoporosis
- ☐ AIDS or HIV positive
- ☐ Migraine headaches or frequent headaches
- ☐ Anemia or blood disorders
- ☐ Abnormal bleeding after extractions, surgery, or trauma
- ☐ Hay fever or sinus trouble
- ☐ Allergies or hives
- ☐ Asthma
- ☐ Chemical Dependency
- ☐ Smoker/ Chew Tobacco
- ☐ Sensitivity to metals
- ☐ Stomach Problems
- ☐ Amoxicillin or other antibiotic Allergy
- ☐ Sulfa Allergy
- ☐ Codeine or other narcotic Allergy
- ☐ Latex Allergy
- ☐ Other Allergy

Please List:______________________________

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Women: Are you pregnant: ☐ yes ☐ no
Taking Birth Control: ☐ yes ☐ no

Whom to Contact in case of an Emergency:______________________Phone Number________________

Name of your physician: ______________________________Phone Number______________

List of current medications you are taking. ______________________________

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Please add anything other medical condition you would like us to know about: ______________________

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Signature of patient (parent/guardian) ______________________________

Parent/Guardian name ______________________________Date ______________