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New Patient Paperwork

Welcome and thank you for choosing Scanlan Family Dentistry. We want your visit with us to be a pleasant, comfortable, and safe experience. Please help us achieve this goal by providing the information requested below.

Personal Information

Name: Last | First | Middle | Nickname

Address: Street Address

City | State | Postal Code

DOB: MM/DD/YYYY **SS#:** XXX-XX-XXXX **DL#:** Drivers License Number

Home #: XXX-XXX-XXXX **Mobile #:** XXX-XXX-XXXX **Work #:** XXX-XXX-XXXX

Email 1: Personal Email **Email 2:** Work Email **Employer:** Organization Name

Emergency Contact: First & Last Name | Phone Number XXX-XXX-XXXX

Is there anyone you would like us to be able to speak with about your care *(healthcare proxy)*? If so please fill-in below:

Proxy Contact: First & Last Name | Phone Number XXX-XXX-XXXX

Insurance Information

Insurance Carrier: Primary Company Name **Subscriber Name:** Last Name, First Name **Subscriber Group #:** Alpha Numeric

Subscriber SS#: XXX-XX-XXXX **Subscriber Employer:** Company Name **Relation To Subscriber:** Self, Spouse, Child, Etc.

Additional Coverage: ☐ Flex Spending Account ☐ Health Savings Account ☐ Secondary Insurance

Other Information

How Did Your Hear About Us?:

☐ Drive-By ☐ Home Mailer ☐ Web Search ☐ Social Media

☐ Coworker ☐ Family Member ☐ Friend ☐ Apt Office / Realtor

Referrer Name:

Who Should We Thank for Referring You? *(If a Coworker, Family Member, or Friend)*

Dental History

Reason for Visit:

What Brought You to Our Office Today?

Special Concerns:

Anything Additional You Think We Should Know About You or Your Reason for Visiting?

Bite (Occlusion)

Do your teeth improperly fit together when you bite? ☐ Yes ☐ No

Do you have a history of broken teeth? ☐ Yes ☐ No

Have you gone a prolonged period with missing teeth? ☐ Yes ☐ No

Are your front teeth *(check a box if yes)*: ☐ Crowded ☐ Chipped ☐ Worn ☐ Thin

Teeth (Dentition)

Are any teeth sore or painful when chewing? ☐ Yes ☐ No

Are any teeth sensitive to hot, cold, or sweet foods/drinks? ☐ Yes ☐ No

Do your teeth trap food? ☐ Yes ☐ No

If yes, is it generalized, or limited to specific area? ☐ Generalized ☐ Specific

Gums (Periodontium)

Do your gums hurt or bleed when brushing, flossing, eating? ☐ Yes ☐ No

Do you find it difficult to manage bad breath? ☐ Yes ☐ No

Do you feel any teeth becoming mobile? ☐ Yes ☐ No

Smile (Esthetics)

Are you concerned about your front teeth: ☐ Color ☐ Length ☐ Shape ☐ Size

Do your teeth improperly fit together when you bite? ☐ Yes ☐ No

Do you have a history of broken teeth? ☐ Yes ☐ No

Bite and Smile Improvements

Would you like to review orthodontic treatment for straightening your smile, improving oral hygiene, and protecting your bite from excessive wear or broken teeth? ☐ Yes ☐ No

Are you interested in whitening or other treatment options to improve your smile? ☐ Yes ☐ No

Would you like to review missing teeth replacements to prevent further teeth breakdown? ☐ Yes ☐ No

Additional Notes:

Please note anything else that you would like to discuss about your bite, teeth, gums, or smile?

Medical History

Please realize that many medications that you may be using and health conditions you may have could make a significant difference in how we treat your dental needs. We ask that you assist us in maintaining our effort for optimal and safe dental care by completing the following information as thoroughly as possible. Furthermore, we genuinely care about your overall health and aim to do our part to support and enhance your well-being. Thank you.

Medications

Please list all prescribed medications as well as over-the-counter medications you are routinely taking and reason for their use *(please provide a separate list if extensive)*.

Allergies

Please indicate any drug or material allergies and specify by name *(antibiotic, narcotic pain medication, latex, etc)*:

General

Do you require antibiotic pre-medication before dental treatment? ☐ Yes ☐ No

Have you been hospitalized in the past 2 years? ☐ Yes ☐ No

Reason:

Do you smoke or use tobacco? ☐ Yes ☐ No

Cardiovascular

- ☐ High Blood Pressure
- ☐ Rheumatic Fever
- ☐ Artificial Heart Valve
- ☐ Congenital Heart Defect
- ☐ Heart Attack *Year:*
- ☐ Congestive Heart Failure
- ☐ Pace Maker
- ☐ Angina / Chest Pain

Neurologic

- ☐ Frequent Headaches

Times of Day:

Triggers:

- ☐ Stroke *(YEAR)*:
- ☐ Epilepsy / Seizures

Triggers:

- ☐ Psychiatric Disorder

Type:

- ☐ History of Drug / Alcohol Abuse
- ☐ Bulimia or Anorexia

Endocrine

- ☐ Adrenal Disorder
- ☐ Diabetes: *Type:* ☐ I ☐ II
- ☐ Thyroids: *Type:* ☐ Hypo ☐ Hyper
- ☐ Hormone Replacement:

Type:

- ☐ Organ Transplant:

Organ: *Year:*

Hematologic

- ☐ Anemia
- ☐ Hemophilia
- ☐ Blood Thinner:

Type: ☐ Asprin ☐ Coumadin ☐ Plavix ☐ Other

- ☐ Hepatatis:

Type: ☐ A ☐ B ☐ C ☐ D

Cancer

Type:

Year Diagnosed:

Pulmonary

- ☐ Tuberculosis (TB)
- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ COPD
- ☐ Emphysema

Pregnancy

- ☐ Pregnant

Weeks:

- ☐ Nursing
- ☐ Birth Control

Genitourinary

- ☐ Kidney Failure

Dialysis Days:

- ☐ STD

Type:

- ☐ HIV / AIDS

Miscellaneous

- ☐ Artifical Joint (s)

Type: ☐ Knee ☐ Hip ☐ Other

- ☐ Arthritis

Type: ☐ Osteo ☐ Rheumatoid

- ☐ Fever Blisters */ Cold Sores*
- ☐ TMD / TMJ Issues
- ☐ Sjogrens Disease
- ☐ Gastric Reflux *(GERD)*
- ☐ Chronic Dry Mouth *(Xerostomia)*

Other Conditions We Should Be Aware Of:

I authorize Dr. Abigail Scanlan and staff to perform radiographs (x-rays), photographs, and/or other routine diagnostic procedures necessary to make a thorough diagnosis of my dental needs. I have received a copy of Scanlan Family Family Dentistry's HIPAA privacy practices. I acknowledge that the information provided here is as complete as possible and to the best of my knowledge.

Patient Signature

Patient Name Date