Lakewood Family Dentistry PC
7700 West 14th Avenue
Lakewood, CO 80214
303-237-4831

Today's Date: _____

New Patient Information Form

Name: _____ ❑ Male ❑ Female

Home Address: _____ Home Phone: _____

City, State, Zip: _____ Work Phone: _____

Previous Address (if less than 3 yrs.) _____ Cell Phone: _____

_____

Preferred Name: _____ SSN: _____

Birthdate: _____ Referred by: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Employer: _____ Occupation: _____

Work Address: _____

Name of Spouse (parent, if minor): _____

Spouse's Employer: _____ Spouse's SSN: _____

Dental Insurance (Primary)

Insured's Name: _____

Insurance Company: _____ Phone: _____

Address: _____ Group #: _____

Insured's Employer: _____ Phone: _____

Insured's SSN: _____ Birthdate: _____

Dental Insurance (Secondary)

Insured's Name: _____

Insurance Company: _____ Phone: _____

Address: _____ Group #: _____

Insured's Employer: _____ Phone: _____

Insured's SSN: _____ Birthdate: _____

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Medical History

Are you under a physician's care now? ❑ Yes ❑ No

If yes, for what? _____

_____

Any Medical Alerts? _____

_____

Family Physician: _____ Phone: _____

Mark any of the following which you have had or have at the present:

Y	N		Y	N		Y	N	
❑	❑	Abnormal Bleeding	❑	❑	Difficulty Breathing	❑	❑	Implants (of any kind)
❑	❑	Alcohol Abuse	❑	❑	Drug Abuse	❑	❑	Kidney Problems
❑	❑	Allergies	❑	❑	Epilepsy	❑	❑	Liver Disease
❑	❑	Anemia	❑	❑	Eye Problems	❑	❑	Low Blood Pressure
❑	❑	Angina Pectoris	❑	❑	Fainting Tendency	❑	❑	Lung Disease
❑	❑	Arthritis	❑	❑	Glaucoma	❑	❑	Mental Disabilities
❑	❑	Artificial Heart Valve	❑	❑	HIV+ AIDS	❑	❑	Mitral Valve Prolapse
❑	❑	Artificial Joint	❑	❑	Hearing Aids	❑	❑	Pace Maker
❑	❑	Asthma	❑	❑	Hearing Impaired	❑	❑	Physical Disabilities
❑	❑	Blood Disease	❑	❑	Heart Attack	❑	❑	Psychiatric Problems
❑	❑	Blood Transfusion	❑	❑	Heart Disease	❑	❑	Rheumatic Fever
❑	❑	Bruise Easily	❑	❑	Heart Murmur	❑	❑	Seizures
❑	❑	Cancer or Tumor	❑	❑	Hepatitis A	❑	❑	Sinus Problems
❑	❑	Chemo/Radiation Therapy	❑	❑	Hepatitis B	❑	❑	Stroke
❑	❑	Congenital Heart Defect	❑	❑	Hepatitis C	❑	❑	TMJ
❑	❑	Depression	❑	❑	High Blood Pressure	❑	❑	Thyroid Problems
❑	❑	Diabetes				❑	❑	Tuberculosis

Are you currently taking any medications? ❑ Yes ❑ No

If so, which? _____

Have you taken or are taking Phen Phen/Redux drugs? ❑ No ❑ Yes, when? _____

Are you allergic to or do you suffer ill effects from any of the following? ❑ Tetracycline ❑ Metals/Jewerly ❑ Latex

❑ Penicillin ❑ Codeine ❑ Dental Anesthesia ❑ Aspirin ❑ Erythromycin ❑ Other: _____

What are the effects? (i.e. rash, upset stomach, etc.): _____

Do you have any other allergies? If so, what? _____

Women Only:

Are you pregrant? ❑ No ❑ Yes, how many weeks? _____

Breast Feeding? ❑ No ❑ Yes

Are you taking routine medicine (Birth Control, etc.)? ❑ No ❑ Yes, which? _____

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Today's Date: _____

Dental History

Date of Last Exam: _____

Date of Last Cleaning: _____

Date of Last X-ray: _____

Do you wear dentures or partials? ..... ❑ ❑

Are you happy with your dentures or partials? ..... ❑ ❑

Are you having dental problems now? .....

If yes, what? _____

Use tobacco? ❑ Yes ❑ No Cigarettes or Chew? ❑ No ❑ Yes How long? _____ How much per day? _____

Have you had bad dental experiences in the past? .....

Have you had any periodontal (gum) treatments? .....

Do your gums bleed, or fee tender or irritated? .....

Are your teeth sensitive to hot, cold, sweets, pressure? .....

Are you unhappy with the appearance of your teeth? .....

Are you aware of grinding or clenching your teeth? .....

Do you have headaches, earaches or neck pains? .....

Do you have pain in your jaw joint? .....

Do you regularly use dental floss? .....

Is there any other medical or dental information that you feel I should know about? _____

_____

Name of Previous Dentist: _____

Address: _____

City, State, Zip: _____

Telephone: _____

Emergency Information (Name, address and telephone of nearest relative not living with you):

Name: _____

Address: _____

City, State, Zip: _____ Telephone: _____

The above information is true to the best of my knowledge.

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk.

Signature: _____

Dentist's Signature: _____ Date: _____