

Advantage Dental & Dentures

Changing Smiles, Enriching Lives

NEW PATIENT INFORMATION

(PLEASE PRINT)

MEDICAL ALERT

How did you hear about Advantage Dental?

☐ Radio ☐ TV/Cable ☐ Direct Mail ☐ Yellow Pages ☐ Newspaper (please specify) _____
☐ Sign ☐ Building ☐ Brochure ☐ Word of Mouth ☐ Insurance Referral ☐ Friend/Relative
☐ Internet/Website ☐ Other _____

Personal Information

Last name _____ First _____ MI _____ (Dr/Mr/Mrs/Ms/Miss)
Male/Female Married/Single Date of Birth ____/____/____ SS# ____-____-____
Address _____ City _____ State _____ Zip _____
Home Phone (____) _____ Employer _____ Work Phone (____) _____
Name of physician _____
Office Number (____) _____ Date of last physical _____
In case of emergency please contact _____ Phone Number _____

Dental Insurance Information

Insurance company _____ Ins. Phone(____) _____ Group # _____
Insured last name _____ First _____ MI _____ (Dr/Mr/Mrs/Ms/Miss)
Male/Female Married/Single Date of Birth ____/____/____ SS# ____-____-____
Insured employer _____ Employer Phone _____

Please answer the following questions:

What is the reason for today's visit? _____

Yes No Are you currently wearing dentures? If yes, when did you receive you last dentures? _____
Yes No Do you use denture adhesives, paste, or powder? If so, please describe _____

Have you ever had...

Yes No Teeth extracted? If so, when _____ Any Problems? _____
Yes No Bleeding problems?
Yes No Bad reaction to anesthesia? (Novocaine)
Yes No Allergic reaction to medications? (Penicillin or Codeine – please circle and/or specify) _____
Yes No Heart attack or heart problems? Please specify _____ If so, when _____
Yes No Prosthetic (false) joints, knee, hip, or valves? Please specify _____
Yes No Circulatory problems?
Yes No Tuberculosis or other chronic ailments? Please specify _____
Yes No Hepatitis?
Yes No Liver disease?
Yes No Diabetes?
Yes No Kidney failure?
Yes No A stroke? If so, when _____
Yes No High or low blood pressure? If so, specify _____
Yes No Cancer? Where? _____ Date diagnosed _____ Radiation _____ Chemotherapy _____
Yes No Immune system disorder?
Yes No HIV/AIDS?
Yes No Fainting spells or seizures?

Yes No Do you take ASPRIN or any other type of blood thinner DAILY including COUMADIN, PLAVIX, etc?
Yes No Are you taking, or have you ever taken prescription medication for osteoporosis?
For Example: FOSAMAX. Please specify _____
Yes No Are you pregnant or nursing?
Yes No Do you smoke or use tobacco products?
Yes No Do you use illegal drugs such as marijuana, cocaine, or methamphetamine?
Yes No Have you ever had a past history of drug or alcohol abuse? Please specify _____
Yes No Do you have any sores in your mouth?
Please list any medicines you currently take, including herbal supplements _____

Other comments _____

To the best of my knowledge the above questions have been answered accurately. I understand that the fee for dentures, extractions, and other services must be paid on the first visit after you are seen by the dentist.

Patient or Guardian Signature _____ Date _____

Dentist Signature _____ Date _____