New Patient Information

Name: _____ Date _____
First Last M

SS# _____ Birthday _____ ❑ Married ❑ Single ❑ Male ❑ Female

Address _____
Street Apt# City State Zip

Home Phone _____ Cell _____ Work _____

Email: _____ Place of Employment _____

Spouse Name _____ Birthday _____ Spouse Employer _____

Cell Phone _____ Work Phone _____ SS# _____

Minors Only

Resides with: ❑ Both Parents ❑ Mother ❑ Father ❑ Other _____

FATHER _____ Father's Birthday _____ SS# _____

Address (If different) _____ Cell Phone: _____

Place of Employment _____ Work Phone: _____

MOTHER _____ Mother's Birthday _____ SS# _____

Address (If different) _____ Cell Phone: _____

Place of Employment _____ Work Phone: _____

Other _____ Birthday _____ SS# _____

Address (If different) _____ Cell Phone: _____

Place of Employment _____ Relationship to Minor _____ Work Phone: _____

Dental Insurance

Primary Policy Holder: _____ Name of Insurance Company: _____

Secondary Policy Holder: _____ Name of Insurance Company: _____

Alternate Contact

OUTSIDE OF FAMILY HOUSEHOLD

Name: _____ Relationship _____

Home Phone _____ Cell _____ Work _____

I hereby authorize directly to the Dental Office of the group insurance benefits otherwise payable to me, I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic, and therapeutic procedures as may be necessary for proper dental care. The information on this page and dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.

X _____ Date _____
Patient or Responsible Party Signature

Moxley
FAMILY DENTAL

Dental History

Patient Name:_____

Reason for Today's Visit _____ Date of last dental care_____

Former Dentist_____ Date of last dental X-rays_____

Address_____

Occupation/Empoyer:_____

How often do you floss? _____ How often do you brush? _____

Medical History

Physician's Name_____ Date of Last visit_____

Have you ever taken any of the group of drugs collectively referred to as Bisphosphonates? These include Zometa, Fosamax, Actonel, Boniva, Reclast, Aredia, Phenphen, Redux Etc. _____

Have you had any serious illness or operations?_____ If yes, Describe_____

Have you ever had a blood transfusion? _____ If yes, give approximate date_____

(Women) Are you Pregnant? Yes or No Nursing? Yes or No Taking birth control pills? Yes or No

Check if you have or have had any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatment
- ☐ Cough, Persistent
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

Medications

List Medications you are currently taking:_____

_____

_____

Pharmacy Name:_____

Phone (_____) _____

Allergies

- ☐ Aspirin
- ☐ Barbiturates (Sleeping Pills)
- ☐ Codeine
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Latex
- ☐ Other

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in completion of this form.

Date_____ Signature_____