NEW PATIENT FORM

PATIENT INFORMATION

Mr. □ Mrs. □ Ms. □ Miss. □ Child □

Name_____ Birthdate:_____ Home Phone:_____
(FIRST) (LAST) (DD/MM/YYYY)

Cell Phone:_____ E-mail:_____

Address:_____ City:_____ Postal Code:_____

Sex: Male □ Female □ Care Card # _____

Whom may we thank for referring you? □ Internet □ Advertising □ Walk-in
□ Another office _____
□ Friend/Family _____

Would you like appointment reminders sent to your phone by text or email?_____

Current Employer and Occupation?_____

Person Responsible for this Account (if patient is a child)?_____

Relationship to Patient?_____

Birthdate?_____ Currently a patient in our office?_____

INSURANCE INFORMATION

Name of insured:_____ Relation to Patient:_____ Birthdate:_____

Employer:_____ Insurance Company:_____

Group #:_____ ID#:_____

Have you used this plan this benefit year?_____

ADDITIONAL INSURANCE INFORMATION

Name of insured:_____ Relation to Patient_____ Birthdate:_____

Employer:_____ Insurance Company:_____

Group #:_____ ID#_____

Have you used this plan this benefit year?_____

DENTAL HISTORY

Reason for today's visit:_____ Date of last dental care:_____

Have you had orthodontic treatment?_____ If yes, are you happy with the results?_____

Are you nervous during dental treatment?_____

Is there anything about the appearance of your teeth you would like to change? □ Yes □ No

If yes, please explain?_____

MEDICAL HISTORY

Physician's Name:_____ Phone Number:_____
Specialist Name:_____ Phone Number:_____
Have you had any serious illnesses/ operations?_____ If yes, describe:_____
Have you ever been told if you require medication before dental appointments?_____
Are you allergic to penicillin?_____
Women Only – Are you pregnant or nursing?_____

List medication you are currently taking:

_____
_____
_____
_____
_____

Allergies:

_____
_____
_____
_____
_____

Check (✓) if you have or have had any of the following:

- □ Rheumatic Fever
- □ Heart murmur
- □ Congenital heart condition
- □ Heart attack
- □ Heart surgery
- □ Pacemaker/artificial valves
- □ Angina
- □ Stroke
- □ High blood pressure
- □ Lung/breathing problems
- □ Tuberculosis (TB)
- □ Kidney problem
- □ Liver disease
- □ Hepatitis/Jaundice
- □ AIDS
- □ HIV positive
- □ Venereal disease
- □ Diabetes
- □ Hemophilia
- □ Anemia
- □ Cancer
- □ Psychiatric care
- □ Epilepsy
- □ Thyroid disease
- □ Cortisone/steroid therapy
- □ Asthma
- □ Stomach ulcer
- □ Joint replacement

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.
I also understand it is my responsibility to inform the office of any changes to my contact information or any changes in my dental insurance. It has been explained to me that although the staff at Dr. Parveen Atwal's office will bill my insurance company directly when possible, any balances not paid by my insurance are my responsibility.
I also consent to my personal physician being contacted if necessary.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient