Doering
Family Dental

DATE: _____/_____/_____

NEW PATIENT INFORMATION FORM - ADULTS

Patient Name: _____ Patient Date Of Birth: _____/_____/_____
Name of Spouse: _____

Home Address: Street: _____
City: _____ State: _____ Zip: _____

Patient Cell Phone: _____
Patient Home Phone: _____
Patient Business Phone: _____

Patient Employed By: _____
Business Address: _____
Present Position: _____
How Long Position Held: _____

Spouse Employed By: _____
Business Address: _____
Present Position: _____
How Long Position Held: _____

Payment Information

Who Will Pay This Account: _____
Purpose of Visit: _____
Patient's Social Security Number: _____
Insured Social Security Number: _____
Spouse's Social Security Number: _____
Name of Dental Insurance Co.: _____
Insured Person's Date of Birth: _____/_____/_____
Email: _____

Referral Information

Please let us know who referred the new patient, if anyone: _____

If you found us as a result of our marketing, please let us know where you remember seeing or hearing about us.
(Please check any and all that you remember.)

___ Friend or Family Referral
___ Google search
___ Google Maps/Local
___ Bing search
___ Bing Maps/Local
___ Email
___ Facebook
___ Yelp!
___ HealthGrades.com
___ ZocDoc.com
___ Phone book (paper version)
___ Online phone book/directory (e.g. YellowPages.com, etc.)
___ My dental insurance company
___ Signage on road or outside of our building
___ Radio ad
___ Print ad in: _____
___ Other: _____

If you found us online, please circle one of the following. I was using a:

COMPUTER or **SMARTPHONE/TABLET** or **BOTH**

Thank you!

Questions? (813) 933-5365 DDoering030@gmail.com

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MEDICAL HISTORY FORM - ADULTS

Please Circle As Appropriate

1. Are you having discomfort or pain?..... YES NO
2. Do you feel very nervous about having dentistry treatment?..... YES NO
3. Have you been a patient in the hospital during the past two years?..... YES NO
4. Have you been under the care of a medical doctor during the past two years?..... YES NO
5. Are you presently taking any medicines, drugs, pills, or herbal supplements? ..... YES NO

   If YES, please list them here:

   _____

   _____
6. Are you allergic to (i.e., itching, rash, swelling of hands, feet, eyes, etc.) or made sick by Penicillin, aspirin, codeine, or any drugs/medications?..... YES NO
7. Do you have a history of previous surgery and anesthesia (sedation)?..... YES NO
8. Have you ever had any excessive bleeding requiring special treatment?..... YES NO
9. Circle any of the following which you have had, or have at present:

HEART FAILURE	EMPHYSEMA	AIDS
HEART DISEASE/ATTACK	COUGH	HEPATITIS A (infectious)
ANGINA (chest pain)	TUBERCULOSIS (TB)	HEPATITIS B (serum)
HIGH BLOOD PRESSURE	ASTHMA	LIVER DISEASE
HEART MURMUR	HAY FEVER	YELLOW JAUNDICE
RHEUMATIC FEVER	SINUS TROUBLE	BLOOD TRANSFUSION
CONGENITAL HEART DEFECT	ALLERGIES/HIVES	DRUG ADDICTION
SCARLET FEVER	DIABETES	HEMOPHILIA
ARTIFICIAL HEART VALVE	THYROID DISEASE	VENEREAL DISEASE (syphilis)
HEART PACEMAKER	X-RAY/COBALT TREATMENT	COLD SORES
HEART SURGERY	CHEMOTHERAPY (for cancer)	EPILEPSY/SEIZURES
ARTIFICIAL JOINT	ARTHRITIS	FAINTING/DIZZINESS
ANEMIA	RHEUMATISM	NERVOUSNESS
STROKE	CORTISONE MEDICINE	PSYCHIATRIC TREATMENT
KIDNEY TROUBLE	GLAUCOMA	SICKLE CELL DISEASE
ULCERS	PAIN IN JAW JOINTS	BRUISE EASILY
MITRAL VALVE PROLAPSE	SLEEP APNEA/SNORING	HIV POSITIVE
CANCER and/or LEUKEMIA		

10. When you walk up stairs or take a walk, do you ever stop because of pain in your chest, shortness of breath, or because you become very tired?..... YES NO
11. Do your ankles swell during the day?..... YES NO
12. Do you use more than two (2) pillows to sleep?..... YES NO
13. Have you lost or gained more than ten (10) pounds in the past year?..... YES NO
14. Do you ever wake from sleep short of breath?..... YES NO
15. Are you on a special diet?..... YES NO
16. Has your medical doctor ever said you have a cancer or tumor?..... YES NO
17. Do you have any disease, condition, or problem not listed above?.....YES NO
18. **WOMEN:** Are you pregnant now?..... YES NO

    Do you anticipate becoming pregnant in the near future? .....YES NO
19. Your primary care doctor's name: _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medicines change, I will inform the doctor of dentistry at the next appointment without fail.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN: _____ DATE: _____/_____/_____