Mayfair DENTISTRY

New Patient Form

Date : _____

Patient Information

_____ _____ _____

Name **Date of Birth** **Signature**

_____

Address (Line 1)

_____

Address (Line 2)

_____ _____ _____

City **State** **Zip Code**

_____ _____ _____

Cell Number **Home Number** **Email address**

How did you hear about us?

- ○ **Patient Referral**
- ○ **Search Engine (E.g. Google)**
- ○ **Yelp**
- ○ **Advertising**
- ○ **Facebook**
- ○ _____

Dental Concerns

We always endeavor to meet your expectations, please describe the main reason for your visit and any concerns you have regarding your dental care.

Main reason for Dental Visit? _____

_____

_____

Primary Benefit Information

If you would like to use your dental benefits for this visit, we would be happy to have this ready for you. Please complete the information below. If you do not have your ID number or group number, we will need the Subscriber's Details to fulfill your request.

_____ _____ _____

Benefit Plan Name **Benefit ID Number** **Group Number**

_____ _____ _____

Subscriber's Name **Subscriber's Date of Birth** **Subscriber's SSN**

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Medical History Update

Date : _____

_____ _____ _____

Name Date of Birth Signature

○ Good ○ Average ○ Poor How would you rate your General Health?

Are you allergic to any Medications?

☐ Penicillin ☐ Amoxicillin ☐ Clindamycin ☐ Aspirin

☐ NSAIDS/Ibuprofen ☐ Sulfa ☐ Anesthetic ☐ _____

If you are allergic to any substances (i.e. Latex, metal, foods), please explain _____

_____

○ Yes ○ No Have you ever been told by your M.D. that you need Antibiotic Prophylaxis before your Dental Appointment?

○ Yes ○ No Do you have any Prosthetic Heart Valves, Past Rheumatic Fever, Past Infective Endocarditis?

○ Yes ○ No Do you have any Total Joint Replacements? _____

○ Yes ○ No Have you ever taken Bisphosphonates? (i.e. Fosamax, Zometa)

Please check all that apply:

☐ Acid Reflux
☐ ADHD
☐ Anemia
☐ Antidepressant Medication
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Birth Control Pills
☐ Bisphosphonates
☐ Blood Disease
☐ Blood Thinners
☐ Cancer
☐ Chemo / Radiation
☐ Chron's
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Fibromyalgia
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ High Cholesterol
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ MS
☐ Multi-Vitamins
☐ Nervous Disorders
☐ Pacemaker
☐ Parkinsons
☐ Past Smoker
☐ Pregnancy
☐ Seizures
☐ Sinus Problems
☐ Smoker
☐ Stomach Problems
☐ Stroke
☐ Thyroid Condition
☐ Tuberculosis
☐ Tumors
☐ Ulcers Venereal Disease

Are you presently being treated for any other illnesses? _____

○ Yes ○ No Have you ever been hospitalized? (Illness/Injury)

○ Yes ○ No Are you subject to frequent headaches?

○ Yes ○ No Have you ever had any dependency on Tobacco or Alcohol?

○ Yes ○ No Females : Are you nursing?

If any conditions need further clarification, please explain _____

List all current Medications _____

_____