NEWMAN DENTAL
Cosmetic & Family Dentistry

Patient Information

Patient Name ______________________________________ Date of Birth ____________________________
Social Security # ____________________________________ Marital Status ___________________________
Patient Address ____________________________________ City, State, Zip __________________________
Home Phone ______________________________________ Work Phone ____________________________
Email address ______________________________________ Cell Phone _____________________________
What is the best way to confirm your dental appointments? _______________________________________
Emergency Contact Name and Number ____
Patient's employer _________________________________ Present position _________________________
Spouse's employer _________________________________ Present position _________________________
Will the fees for our services be offset by dental insurance? Yes / No
Subscriber Name _________________________________ Relationship to patient _____________________
Subscriber Date of Birth: __________________________Name of Dental Ins. _________________________
Identification Number _________________________________ Group Number _______________________
Who may we thank for referring you to our office?____

Dental History

Are you aware of any dental problems at this time? ____
How long has it been since you have been to a dentist? ____
What was done then? ____
Previous Dentist's name ________________________________ Address ______________________________
Have you ever been told to take antibiotics prior to your dental appointment? Yes/No ________________
Have you had any problems or complications with previous dental treatment?

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Have you ever had any of the following dental procedures done? If so, please explain.

Gum Treatments or Periodontal Surgery? Yes/No ____
Orthodontic Treatment Yes/No ____
Oral Surgery Yes/No ____
Endodontic Treatment Yes/No ____
Dental Implants Placed Yes/No ____
Have you ever whitened your teeth? Yes/No Are you interested in whitening? _____________________
Have you lost any teeth or have any teeth been removed? Yes/No Why? ____________________________

Do you experience any of the following:

❑Yes ❑No Hot/Cold Sensitivity
❑Yes ❑No Unpleasant Breath
❑Yes ❑No Bleeding or Tender Gums
❑Yes ❑No Food gets caught easily
❑Yes ❑No Frequently get cavities
❑Yes ❑No Clench or grind your teeth
❑Yes ❑No Difficulty opening or closing
❑Yes ❑No Jaw clicks, pops, or locks
❑Yes ❑No Pain or soreness by ear or in face
❑Yes ❑No Build up a lot of plaque/calculus

How often do you brush? ________________ How often do you floss? ______________________________
What other products/rinses do you use? ____
Do you usually have teeth numbed for dental work? Yes/No
Do you snack or drink liquids (other than water) in between meals? Yes/No How frequently?___________
If you could change anything about your teeth or smile what would that be? _________________________
Are you planning to keep your remaining teeth your whole lifetime? Yes/No _________________________
Is there anything we can do to make your dental appointment more comfortable?____________________

I certify that the above information is complete and accurate.

Patient/Guardian Signature ____ Date: ____________
Dentist's Initials ____ Date: ____________

Complete Reverse Side