Dove Dental Smiles
Family & Cosmetic Dentistry

New Patient Form

Date:_____ Name: _____ I prefer to be called: _____

Address: _____City: _____ State: ____ ZIP: _____

Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ I prefer to be contacted via: □ home ph. □ Cell □ email □ text

Date of Birth _____ □ Male □ Female Who may we thank for referring you? _____

Check appropriate Box □ Minor □ Single □ Married □ Divorced □ Separated □ Widowed

Person to contact in case of emergency: _____Phone: _____

Responsible Party

Name: _____ Relationship to Patient: _____

Address: _____City: _____ State: ___ ZIP: _____

Assign Insurance Benefits to Dr. Shirley Irudayaraj (Y) (N)

Signed _____ Date: _____

Insurance Information

Name of Insured _____ Date of Birth _____ Relationship to Patient _____

SSN# _____ Employer _____Work Phone: _____

1) **Insurance Company _____ Group # _____ ID# _____**

Insurance Phone # _____

2) **Insurance Company _____ Group # _____ ID# _____**

Insurance Phone # _____

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Patient Dental Health

Why have you come in to see us today? (e.g. Pain, checkup, etc.)

_____

_____

Previous Dentist: _____ Last Visit _____ Date of Last Cleaning _____

Reason for changing dentists: _____

Problems with past dental treatment: _____

Are you nervous about seeing a dentist? (Y) (N) If yes, why: _____

How often do you brush? _____ Do You Floss? (Y) (N) How Often? _____

Do you Pre-medicate for dental treatment? (Antibiotics) (Y) (N)

What are your dental priorities? (e.g. dental health, problem focus, etc.) _____

Patient Medical History

I consider my health to be (please check one) □ Excellent □ Good □ Fair □ Poor

Do you have any of the following (please circle Y for yes and N for no)

Y N Heart Disease	Y N Liver Disease	Y N Heart Murmur/Mitral Valve Prolapse
Y N Jaundice	Y N Stroke	Y N Hepatitis Type: ___
Y N Congenital Heart Lesions	Y N Diabetes	Y N Rheumatic Fever
Y N Excessive Urination and/or thirst	Y N Abnormal Blood Pressure	Y N Infectious Mononucleosis (Mono)
Y N Anemia	Y N Herpes	Y N Prolonged Bleeding Disorder
Y N Arthritis	Y N AIDS	Y N Immune Suppressed Disorder
Y N Tuberculosis or Lung Disease	Y N Hearing Loss	Y N Sexually Transmitted Disease
Y N Asthma	Y N Kidney Disease	Y N Hay fever
Y N Tumor or Malignancy	Y N Fainting Spells	Y N Glaucoma
Y N Sinus Trouble	Y N Cancer/Chemotherapy	Y N Epilepsy/Seizures
Y N Radiation Treatment	Y N History of Emotional or Nervous disorder	
Y N Ulcers	Y N History of Drug Addiction	Y N Implants/Artificial Joints: Hip, Knee, etc.

Y N I smoke or use tobacco. If yes, how much per day?___ How many years?_____

Y N I have consumed alcohol within the last 24 hours.

Y N Take oral Bisphosphonate? (Fosamax/Actonel/Boniva) Y N Take IV Bisphosphonate?

Women: Are you taking Birth control medication? **Y N** Are you /could you be pregnant or nursing? **Y N**

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Y N Do you have any other medical problem or medical history **Not listed on this form?** _____

Are you allergic to any of the following?

Y N Aspirin **Y N** Ibuprofen
Y N Sulfa/Sulfites/Sulfides
Y N Penicillin **Y N** Other _____
Y N Codiene/bicodin/Valium
Y N Local Anesthetics (Novocaine)
Y N Latex **Y N** Plastics **Y N** Metals

Please List all Medications you are currently taking:

_____
_____ for _____
_____ for _____
_____ for _____
_____ for _____
_____ for _____

Physician's Name _____ Phone #: _____ **Patient Initals:_____ Date:_____**

Please circle Y for yes or N for no

Y N I clench or grind my teeth during the day or while sleeping.

Y N Jaw or joint pain.

Y N My gums bleed while brushing or flossing.

Y N My gums feel tender or swollen.

Y N I like my smile.

Y N I have problems eating.

Y N I prefer tooth colored fillings.

Y N I have had orthodontics.

Y N I avoid brushing part of my mouth due to pain.

Y N I have had a facial or jaw injury.

Y N I want my teeth whiter.

Y N Do you have frequent or regular headaches? Upon awakening/late afternoon

Y N Are your Jaw muscles sore or tender?

Y N Are your joints sore or tender when you eat or chew?

Y N Do your joints lock when you are trying to open or close?

Y N Have you ever received an injury to your jaw or face? If yes, Describe:

_____

_____

Y N Do your joints make any noise such as snapping, clicking, or popping?

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Patient Medical History – Continued…

Y N Do you have any teeth that are sensitive, sore, aching, or uncomfortable?

Y N Have you ever worn a splint or night guard? If yes, how many:_____ How long ago? _____

Y N Are you taking or have you taken any medication for these symptoms? If yes, describe:

_____

_____

Y N Have you ever seen a dentist or a TMJ specialist for treatment of any of the above symptoms?

If yes, how long ago? _____

History Updates/Notes: _____

_____

_____

_____

_____**Patient Initals:_____Date:_____**