alpine dental health
We make it easy for you to smile

Please use this form to provide us with your health history and other important information. We know that medical paperwork can be tedious; however, the few minutes you invest to answer each of these questions will help us care for you in the best possible way.

New Patient Form

1. Patient information

Today's Date: _____

First Name, Middle Initial, Last Name | Preferred Name | Home Phone | Business/Cell Phone

Address

Occupation | Height | Weight | Date of Birth | Sex: M F

SS# or Patient ID | Email | Driver's License #

Whom may we contact in an emergency? Name _____ Relationship _____

Home Phone | Cell Phone

Address

If you are completing this form for another person, what is your relationship to that person?

Your Name | Relationship

Do you have any of the following diseases or problems? (Check DK if you don't know the answer.) Yes No DK

Active Tuberculosis . . . . . .
Persistent cough greater than a 3 week duration . . . . . .
Cough that produces blood . . . . . .
Been exposed to anyone with tuberculosis . . . . . .

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist, or call our office.

2. Referral Information

Whom may we thank for referring you to our office? _____

3. Insurance Information PRIMARY DENTAL INSURANCE

Insurance Company Name | Insurance Company Phone | Group # (Plan, Local, or Policy #)

Insurance Company Address

Policy Owner's Name | Relationship to Patient

Policy Owner's Address | Policy Owner's Phone#

Policy Owner's Date of Birth | Policy Owner's SS# | Policy Owner's Employer

SECONDARY DENTAL INSURANCE

Insurance Company Name | Insurance Company Phone | Group # (Plan, Local, or Policy #)

Insurance Company Address

Policy Owner's Name | Relationship to Patient

Policy Owner's Date of Birth | Policy Owner's SS# | Policy Owner's Employer

If you are utilizing dental insurance we will be happy to aid you in maximizing your benefits. It must be understood though that dental insurance is a relationship between you, the insurance company, and your employer. At Alpine Dental we will always recommend the treatment that is best for our patient. This is not always what the insurance company is willing to pay for. Therefore, ultimately the patient is financially responsible to Alpine Dental Health for any charges not paid by their insurance company.

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4. Dental Health Information

What is the main reason for your visit to Alpine Dental Health?

Are you currently experiencing dental pain or discomfort?

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Do you frequently have a dry mouth?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic treatment (braces)?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping, or discomfort in your jaw?	☐	☐	☐
Do you grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam: _____ What was done at that time? _____ Date of last dental x-rays: _____

Do you wish your teeth were whiter? ☐ ☐ ☐ Would you like straighter teeth? ☐ ☐ ☐

How do you feel about the appearance of your teeth when you smile? _____

5. Medical Information

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician Name _____ Phone _____ Address (city, state, zip) _____

Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐
If yes, what condition is being treated? _____			
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐
If yes, what was the illness or problem? _____			
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

Joint Replacement Have you had an orthopedic total joint replacement (hip, knee, elbow, finger)?	☐	☐	☐

Date: _____ If yes, have you had any complications? _____

Are you taking or scheduled to begin taking either of the medications alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's Disease?	☐	☐	☐

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Date treatment began: _____

Allergies Are you allergic to or have you had a reaction to:
(To all yes responses, specify type of reaction.)

	Yes	No	DK
Local anesthetics	☐	☐	☐
Aspirin	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐	☐
Sulfa drugs	☐	☐	☐
Codeine or other narcotics	☐	☐	☐

	Yes	No	DK
Metals	☐	☐	☐
Latex (rubber)	☐	☐	☐
Iodine	☐	☐	☐
Hay fever/seasonal	☐	☐	☐
Animals	☐	☐	☐
Food	☐	☐	☐

Other _____

WOMEN ONLY Are you: Pregnant? ☐ ☐ ☐ Number of weeks: _____

Taking birth control pills or hormonal replacement?
Nursing? ☐ ☐ ☐

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New Patient Form

5. Medical Information *continued*

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐

Do you use tobacco? ☐ smoking ☐ snuff ☐ chew

If so, how interested are you in stopping?

☐ VERY ☐ SOMEWHAT ☐ NOT INTERESTED

	Yes	No	DK
Do you drink alcoholic beverages?	☐	☐	☐

If yes, how much alcohol did you drink in the last 24 hours? _____

If yes, how much do you typically drink in a week? _____

Please mark your response to indicate whether you have had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐

Congenital heart disease (CHD):	Yes	No	DK
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of congenital heart disease (CHD).

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐

	Yes	No	DK
Rheumatoid arthritis	☐	☐	☐
Autoimmune disease	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy /Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/Persistent Heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐

	Yes	No	DK
Glaucoma	☐	☐	☐
Hepatitis, Jaundice or Liver Disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or Seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: _____			
Sleep disorder	☐	☐	☐
Mental health disorders	☐	☐	☐
If yes, specify: _____			
Recurrent infections	☐	☐	☐
Type of infection: _____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Sever headaches/migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

	Yes	No	DK
Do you have any disease, condition or problem not listed above that you think we should know about?	☐	☐	☐

Please explain: _____

6. Signatures

A. Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries made above have been answered to my satisfaction. I will not hold my dentist, or his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

I give permission for Alpine Dental Health staff to speak with the following person(s) about my dental health, finances and records:

Name	Relationship	Name	Relationship
_____	_____	_____	_____

Signature of Patient/Legal Guardian: _____ Date: _____

B. Acknowledgement of receipt of Notice of Privacy Practices.

I, _____ have received a copy of this office's Notice of Privacy Practices.

Signature of Patient/Legal Guardian: _____ Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual was unwilling to sign: Other: