Welcome to Newport Beach Dental

Patient's Name____ Date________________
Last First MI

Preferred Name_______________________ ☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Address______________________________City ________________ State _____Zip____________

Social Security # _______________Birth Date____________ E-mail________________________

Phone (Home) ________________ (Work) ______________ Ext_______Cell Phone______________

Employer Name______________________________ Occupation______________________________

Address: ____
Street City State Zip

Preferred contact for appointment confirmation: Home Phone ☐ Cell Phone ☐ Email ☐ Text ☐ Work Phone ☐

Emergency Contact: Name: ______________________ Phone: _______________________________

◆ Person Responsible for Payment (if other than patient)

Name: ___________________________☐ Male ☐ Female ☐ Married ☐ Single ☐ Other_____________

Social Security # ____________________Birth Date_____________ E-Mail____________________

Phone (Home)______________ (Work)_____________ Ext:_______ Cell Phone_________________

Address___________________________________City____________ State_____ Zip___________

Employer Name______________________________ Occupation______________________________

Address:____
Street City State Zip Code

◆ Insurance – Primary

Name of Insured_____________________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date _____________ ID # ________________ Group #________________________

Insured's Address_____________________________City_______________State_____Zip_________

Insured's Employer Name____

Address____

Patient's relationship to insured ☐ Self ☐ Spouse ☐ Child ☐ Other_____________________________

Insurance Plan Name and Address____
____

◆ Insurance – Secondary

Name of Insured_____________________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date______________ ID # ______________________Group #____________________

Insured's Address_____________________________City_______________State_____Zip_________

Insured's Employer Name____

Address____

Patient's relationship to insured ☐ Self ☐ Spouse ☐ Child ☐ Other_____________________________

Insurance Plan Name and Address____
____

PATIENT____**DOB**______________________

Medical History

Do you have or have you ever had any of the following? Please check those that apply.

☐ Allergies
☐ Anemia
☐ Angina
☐ Arthritis
☐ Artificial Heart Valve
☐ Artificial Joints ____________
☐ Asthma
☐ Blood Transfusion ________
☐ Cancer ______________
☐ Chemotherapy
☐ Congenital Heart Defect
☐ Diabetes
☐ Dizziness
☐ Emphysema
☐ Epilepsy
☐ Excessive Bleeding
☐ Facial Surgery

☐ Fainting
☐ Frequent headaches
☐ Hay Fever
☐ Heart Attack
☐ Heart Disease
☐ Heart Murmur
☐ Hemophilia
☐ Hepatitis – **Type** _______
☐ High Blood Pressure
☐ HIV / AIDS
☐ Kidney Disease
☐ Liver Disease
☐ Low Blood Pressure
☐ Migraines
☐ Mitral Valve Prolapse
☐ Pacemaker
☐ Psychiatric Problems

☐ Radiation Therapy
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sexually Transmitted Disease
Type_______________
☐ Shingles
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Thyroid Problems
☐ Persistent Cough
☐ Tuberculosis
Date_____________
Drug or Alcohol Abuse

☐ Cough that produces blood
☐ Been exposed to anyone with Tuberculosis
☐ Ulcers

Allergies
☐ Penicillin Allergy
☐ Latex ______________
☐ ________________

Women only:
☐ Pregnancy
Due Date________
Are You Nursing?_____
Are Taking Birth Control Pills?______________

- Do you use tobacco (smoking, snuff or chew)? ☐ Yes ☐ No If yes, how much?___________
- Do you drink alcoholic beverages? ☐ Yes ☐ No If yes, how much alcohol do you typically drink in a week? ______________ ___
- Do your gums bleed when you brush or floss? ☐ Yes ☐ No How often do you brush?: _______ How often do you floss?:_______
- Are your teeth sensitive to cold, hot, sweets or pressure? ☐ Yes ☐ No • Do you brux or grind your teeth? ☐ Yes ☐ No
- Name of your Primary Care Physician____ Phone____________________
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:____
- Do you have any health problems that need further clarification or were not listed above? ☐ Yes ☐ No
  If yes, please explain:____
- List any medications you are taking **(if none write NONE)**: ____

To the best of my knowledge, all of the preceding answers and information provided are true and correct.
If I ever have any change in my health, I agree to inform the doctor at the next appointment.

▶ ____ Reviewed by ▶ ____________________________ Date: ___________
Signature of patient, parent or guardian

How did you hear about our office? ☐ Another patient ☐ Internet ☐ Insurance Company ☐ Dental Office ☐ Verizon Yellow Pages
☐ Community Yellow Pages ☐ Newspaper ☐ Work ☐ Other____
Name of person or office referring you to our practice____

- Date of Last Dental Visit___________________ Reason for this visit____
- If you could change one thing about your smile what would it be?____
- Why did you leave your last dentist? ____
- What did you like most about any dentist you have ever seen? ____
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No If yes, please explain:

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