



# NEW PATIENT FORM

Welcome to Divine Dental Clinic! Please, answer the following questions to help us to better care for your dental needs. All information will be confidential and is for our records only.

DR MR MRS MS MISS MSTR Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Birth date (M/D/YR) \_\_\_\_\_ Male( ) Female( )

Unit/Building \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ POSTAL CODE \_\_\_\_\_

Phone HM \_\_\_\_\_ WK \_\_\_\_\_ CELL \_\_\_\_\_

Email \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

## MEDICAL HISTORY

Name of Physician/Clinic \_\_\_\_\_ phone \_\_\_\_\_

Women only – are you pregnant? Y N If yes, due date \_\_\_\_\_

Have you been hospitalized in the past 5 years? Y N If yes, for what reason? \_\_\_\_\_

Have you ever had an unusual reaction/ allergy to any medication? Y N  
(I.e.: penicillin, codeine, local anesthetic, sulpha, NSAIDs, etc) \_\_\_\_\_

### Please check all of the conditions that you have now or have had in the past

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Asthma/ Hay Fever            | <input type="checkbox"/> Cancer                    | <input type="checkbox"/> Diabetes                                   |
| <input type="checkbox"/> Sinus Trouble                | <input type="checkbox"/> Aids/ HIV+                | <input type="checkbox"/> High/ Low Blood Pressure                   |
| <input type="checkbox"/> Heart Murmur                 | <input type="checkbox"/> Heart Attack/ Surgery     | <input type="checkbox"/> Artificial Joints/ Heart Valves/ Pacemaker |
| <input type="checkbox"/> Frequent Alcohol Consumption | <input type="checkbox"/> Epilepsy/Seizure Disorder | <input type="checkbox"/> Substance Abuse                            |
| <input type="checkbox"/> Arthritis/Rheumatism         | <input type="checkbox"/> STD's                     | <input type="checkbox"/> Stomach Disorders                          |
| <input type="checkbox"/> Psychiatric Disorders        | <input type="checkbox"/> Lung Disease/Tuberculosis | <input type="checkbox"/> Hepatitis/Jaundice/Liver Disease           |
| <input type="checkbox"/> Frequent/Severe Headaches    | <input type="checkbox"/> Thyroid Disease           | <input type="checkbox"/> Blood Disorders/Anemia                     |

If you have any disease, condition or problem not mentioned about, please describe \_\_\_\_\_

Please list medications you are currently taking (prescription and/or non-prescription) \_\_\_\_\_

Do you smoke?(Tobacco, marijuana ,other)  
How many per day and for how long? \_\_\_\_\_

## DENTAL HISTORY

Name of previous dentist/clinic \_\_\_\_\_ Date of last dental visit \_\_\_\_\_ Reason for visit with us \_\_\_\_\_

- |  |   |
|--|---|
| 1) Have you had regular dental visits in the past? <b>Y N</b>                  | 7) Do you get popping or clicking sounds from your jaw? <b>Y N</b>                                |
| 2) Are you currently having any dental pain? <b>Y N</b>                        | 8) Are you aware of clenching or grinding your teeth? <b>Y N</b>                                  |
| 3) Have you been treated for periodontal (gum) disease in the past? <b>Y N</b> | 9) Have you had surgery/radiation treatment to your head/neck? <b>Y N</b>                         |
| 4) Is there a family history of periodontal (gum) disease? <b>Y N</b>          | 10) Have you ever had orthodontic treatment (braces)? <b>Y N</b>                                  |
| 5) Do your gums bleed when you brush or floss? <b>Y N</b>                      | 11) Have you ever had a bad reaction or abnormal bleeding with past dental procedures? <b>Y N</b> |
| 6) Are you aware of any sores or lumps in your mouth? <b>Y N</b>               | 12) Have you had any trauma to your face or jaw? <b>Y N</b>                                       |

If you answered yes in any of the questions above, please, give a brief explanation. (Use the number of the question in your answer)

How often do you brush your teeth? \_\_\_\_\_ How often do you floss? \_\_\_\_\_  
Is there anything about the appearance of your teeth that concerns you? \_\_\_\_\_

When receiving dental treatment would you consider yourself (circle the preferred option):  
Relaxed Mildly apprehensive Nervous but under control Extremely nervous

What concerns you most about receiving dental treatment? \_\_\_\_\_

What, if any, is/are your current dental issue(s)? \_\_\_\_\_

### Consent to treatment

- I certify that the above information is correct to the best of my knowledge.
- I authorize the doctor upon consultation and direct consent from the patient/parent/guardian to perform diagnostic procedures, treatment, and medication in the connection with the patient's dental needs.
- I understand that responsibility for payment of dental services, including insurance or otherwise, is due and payable at the time services are rendered and despite any dental insurance. I am ultimately responsible for any fees withheld by the insurance company.

\_\_\_\_\_ Date

\_\_\_\_\_ Signature

Patient  Parent  Guardian



## OFFICE POLICY REGARDING DENTAL PLANS

Name of Insurer \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Certificate or ID # \_\_\_\_\_ Group or Plan # \_\_\_\_\_  
 Plan Holder Name (If not yourself) \_\_\_\_\_

As a courtesy and convenience to you, our patient, Divine Dental Clinic accepts dental plans upon confirmation of your coverage and the information your insurance company discloses. Based on this information, we are able to provide you with **estimates** of treatment required to the best of our knowledge.

Your dental policy is a contract between you, your employer and your insurance company. Should your coverage terminate or change in any way, we can only be notified of this by **YOU**, the patient. If treatment is not paid by your dental plan, it is the sole responsibility of you, the patient, to cover all costs.

We bill all treatment done on the day the service is rendered. If we have not received payment from your insurance company within 60 days of services rendered, then this claim becomes your responsibility. Any portion of any claim submitted to your insurance company that is not paid in a timely manner will become your responsibility.

Payment for services rendered is expected in full upon us notifying you by phone, email or mail. Should payment not be made, Divine Dental Clinic may exercise the right to transfer your account to a Debt Collection Agency.

## OFFICE RESCHEDULING POLICY

Our office kindly requests 2 full business days' notice for an appointment change. A missed appointment fee of \$100 will be charged if insufficient notice is provided. Some appointments over 1 hr may require a deposit (treatment dependent). All meetings scheduled within 24 hours will be considered confirmed at the time of booking. We offer an automated reminder service to ensure you are notified and reminded of all appointments scheduled with us.

I have read and understand the above and agree with the terms and conditions.

\_\_\_\_\_  
 Name (Please print)

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Signature

Patient  Parent  Guardian