STEWART FAMILY DENTISTRY

Kenneth W. Stewart DMD *Michael Kanellis DMD*

New Patient Information Form

Name:_____ ○ Male ○ Female

Home Address:_____ Home Phone:_____

City, State, Zip:_____ Cell Phone:_____

Preferred Name:_____ SSN:_____

Birthdate:_____ Referred by:_____

Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed Email:_____

Employer:_____ Occupation:_____

Spouse Name:_____ Parent/Guardian (if minor):_____

Employer:_____ SSN:_____

Dental Insurance (Primary)

Insured's Name:_____ Employer:_____

Insurance Company:_____ Phone Number:_____

Claim Mailing Address:_____ Group #:_____

Insured's SSN/ID #:_____ Birthdate:_____

Dental Insurance (Secondary)

Insured's Name:_____ Employer:_____

Insurance Company:_____ Phone Number:_____

Claim Mailing Address:_____ Group #:_____

Insured's SSN/ID #:_____ Birthdate:_____

Insurance Assignment:

I hereby authorize the above insurance companies to pay the benefits relative to the services performed on my claim to Stewart Family Dentistry. I understand that I am financially responsible for all charges not covered by insurance.

Signature X_____ Date:_____

Consent:

1. I authorize the staff to take radiographs or utilize any other diagnostic aids to make a thorough diagnosis.
2. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use appropriate medication and therapy indicated for such treatment. I understand that dental treatment and the use of anesthetic agents embodies a certain risk, including but not limited to nerve damage, bleeding, swelling and infection. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that 1 ½ % finance charge (18% APR) may be added to my account.
4. Lastly, I understand that where appropriate, credit bureau reports may be obtained.

Patient Signature X_____ Date:_____

Guardian (if minor) X_____ Relationship to Patient:_____

MEDICAL INFORMATION

		Yes	No
1.	Are you in good health?	○	○
2.	Have you been a patient in the hospital during the last two years?	○	○
3.	Have you been under the care of a medical doctor during the past year?	○	○
	Physician's Name:_____ Phone:_____		
4.	Have you taken any medication or drugs during the past two years?	○	○
5.	Are you currently taking any medication or drugs?	○	○
	If yes, please list_____		
6.	Are you currently or have you in the past taken bisphosphonate drugs? (Actonel, Boniva, Fosamax etc.)	○	○
7.	Are you allergic or sensitive to any medications or anesthetics?	○	○
	If yes, please list_____		
8.	Do you have any allergies or sensitivities to penicillin, local anesthetics, codeine or aspirin?	○	○
9.	Do you have any allergies or sensitivities to metals, plastics or latex products?	○	○
10.	Has a doctor ever told you that you need antibiotics prior to dental treatment?	○	○
11.	Do you smoke or use tobacco products?	○	○
12.	Do you use recreational drugs of any sort?	○	○

Please indicate which of the following you have at present, or have had. Choose Yes or No to each item.

Heart Failure	○ Yes ○ No	Cortisone Medication	○ Yes ○ No	Drug Addiction	○ Yes ○ No
Heart Disease or Attack	○ Yes ○ No	Kidney Trouble	○ Yes ○ No	Hepatitis A (Infectious)	○ Yes ○ No
Angina Pectoris	○ Yes ○ No	Ulcers	○ Yes ○ No	Hepatitis B (Serum)	○ Yes ○ No
Congenital Heart Disease	○ Yes ○ No	Diabetes	○ Yes ○ No	Venereal Disease	○ Yes ○ No
Heart Murmur	○ Yes ○ No	Thyroid Problems	○ Yes ○ No	A.I.D.S.	○ Yes ○ No
High Blood Pressure	○ Yes ○ No	Glaucoma	○ Yes ○ No	H.I.V. Positive	○ Yes ○ No
Stroke	○ Yes ○ No	Tuberculosis	○ Yes ○ No	Cold Sores/Fever Blisters	○ Yes ○ No
Arteriosclerosis	○ Yes ○ No	Emphysema	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No
Mitral Valve Prolapse	○ Yes ○ No	Chronic Cough	○ Yes ○ No	Blood Transfusion	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Sinus Trouble	○ Yes ○ No	Hemophilia	○ Yes ○ No
Heart Pacemaker	○ Yes ○ No	Asthma	○ Yes ○ No	Anemia	○ Yes ○ No
Heart Surgery	○ Yes ○ No	Hay Fever	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Rheumatic Fever	○ Yes ○ No	Allergies or Hives	○ Yes ○ No	Bruise Easily	○ Yes ○ No
Arthritis	○ Yes ○ No	Cancer	○ Yes ○ No	Liver Disease	○ Yes ○ No
Rheumatism	○ Yes ○ No	Radiation Therapy	○ Yes ○ No	Yellow Jaundice	○ Yes ○ No
Artificial Joints (hip,knee)	○ Yes ○ No	Chemotherapy	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No
Orthopedic Surgery (Pins, Plates, Screws)	○ Yes ○ No	Tumors	○ Yes ○ No	Fainting or Dizzy Spells	○ Yes ○ No
		Unexplained Weight Loss	○ Yes ○ No	Chronic Cough (over 3 weeks)	○ Yes ○ No
Night Sweats	○ Yes ○ No	Blood from Coughing	○ Yes ○ No		

13. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired ○ Yes ○ No
14. Have you ever come in close contact or lived in a concentrated housing environment with a Tuberculosis patient? ○ Yes ○ No
15. Do you have any diseases, conditions or problems not listed? ○ Yes ○ No
    If YES, please list_____

FOR WOMEN ONLY: Are you pregnant? ○ Yes Due Date: _____ ○ No
Are you nursing? ○ Yes ○ No Are you taking birth control pills? ○ Yes ○ No

Do you have a specific dental problem?_____
How long since your last dental visit?_____ Name of previous dentist:_____

Specific Dental Concerns:

Bleeding gums	○ Yes ○ No	Unpleasant breath or bad taste	○ Yes ○ No
Loose Teeth	○ Yes ○ No	Sensitive to Hot, Cold, Sweets, Pressure	○ Yes ○ No
Sensitive to Biting	○ Yes ○ No	Clenching or Grinding of Teeth	○ Yes ○ No
Popping/Clicking of Jaw	○ Yes ○ No	Food Catching Between Teeth	○ Yes ○ No
Pain on Opening/Closing	○ Yes ○ No	Misaligned or Misshapen Teeth	○ Yes ○ No
Headache or Muscle Pain	○ Yes ○ No	Discolored Teeth	○ Yes ○ No

Have you ever had orthodontic treatment? ○ Yes ○ No Have you ever been told you have a gum problem? ○ Yes ○ No
Have there been any problems or complications related with previous dental treatment? ○ Yes ○ No
Does dental treatment make you nervous? ○ Yes ○ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature X_____ **Date:**_____