PARKER & McDANIEL
Family Dentistry

Today's Date: _____

NEW PATIENT INFORMATION

PATIENT LEGAL NAME: _____ PREFERRED NAME: _____ SSN#: _____

ADDRESS _____ CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER (H): _____ (C): _____ E-MAIL: _____

PREF. CONTACT METHOD: Phone: ☐ Cell ☐ Home ☐ Text ☐ E-Mail

SEX: ☐M ☐F ☐Prefer not to say BIRTHDATE: _____ AGE: _____

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widow

EMPLOYER: _____ OCCUPATION: _____

PREF. PHARMACY: _____ EMERGENCY CONTACT: _____

*Whom May we thank for referring you?: _____

PRIMARY DENTAL INSURANCE

Subscriber: _____ Relationship to Patient: _____

Subscriber DOB: _____ Subscriber SSN: _____

Address (If different from patient): _____ Phone #: _____

Subscriber/Guarantor Employer: _____ Occupation: _____

Dental Insurance Company: _____ Contact#: _____

Subscriber ID (Member ID#): _____ Group#: _____

Insurance Company Claims Address: _____

- Are you in any dental discomfort today? ☐ No ☐ Yes If Yes, please describe, including time frame: _____

_____

- Check (✓) if you have had problems with any of the following:

☐ Bad breath	☐ Food collection between teeth	☐ Periodontal treatments	☐ Sensitivity to sweets
☐ Bleeding gums	☐ Grinding or clenching teeth	☐ Sensitivity to cold	☐ Sensitivity when biting
☐ Clicking or popping jaw	☐ Loose teeth or broken fillings	☐ Sensitivity to hot	☐ Sores or growths in mouth
☐ Do you snore?			

How often do you brush? _____ How often do you floss? _____ Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? _____

Other information about your dental health or previous treatment? _____

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

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Would you be interested in talking to Dr. McDaniel or Dr. Parker about any of the following?

- ☐ Teeth Whitening
- ☐ Changing silver fillings to white
- ☐ Veneers
- ☐ Invisalgin
- ☐ Vivera Retainers (Invisible, removable retainers)

Medical History

Primary Physician's Name:_____ Office #: _____

Have you had any serious illnesses or operations?

- ☐ No
- ☐ Yes, if Yes, please explain including approximate dates: _____
- ☐ Have you ever had a blood transfusion? If yes, Please provide approximate date(s): _____

Women: Are you Pregnant? ☐ Yes ☐ No

Please list all medications you are currently taking:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Do you have and Food or Drug Allergies?

_____
_____
_____
_____
_____

Please check if you have any of the following:

- ☐ AIDS
- ☐ Anaphylaxis caused by:_____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Valves
- ☐ Artificial Joints, date of placement:_____
- ☐ Aspirin Daily
- ☐ Asthma
- ☐ Blood Disease:_____
- ☐ Blood Thinners
- ☐ Cancer
- ☐ Chemotherapy Treatment
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting Episodes
- ☐ Food Allergies
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems, describe if yes: _____
- ☐ Hemophilia
- ☐ Herpes
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Jaw Pain
- ☐ Kidney Disease or Malfunction
- ☐ Pacemaker, date of placement:_____
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of feet or ankles
- ☐ Thyroid Disease
- ☐ Tobacco Habit
- ☐ Tuberculosis
- ☐ Ulcers, location:_____
- ☐ Venereal Disease
- ☐ Anything other condition or disease not listed?