New Patient Form

Please complete all sections. Indicate **N/A** if not applicable.

Patient Information

Name: _____
First Last Middle Initial

Address: _____
Street City Postal Code Province

Phone Number: _____
Cell Home Business

Email: _____

Emergency Contact: _____ Phone Number: _____

How did you hear about us? _____
If referred by a patient, please provide name.

Date of Birth: ____/___/_____
DD / MM / YYYY

Languages:
- ☐ English
- ☐ Spanish

Gender:
- ☐ Female
- ☐ Male
- ☐ Non-Binary
- ☐ Prefer not to say

Medical Information

Have you, currently or ever received treatment for the following conditions? Please check all that apply:

- ☐ Arthritis
- ☐ Asthma/Breathing Problems
- ☐ Bleeding Disorder/Problem
- ☐ Cancer
- ☐ Chest pain/Angina
- ☐ Diabetes
- ☐ Drug/Alcohol Dependency
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Condition
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ Joint Surgery/Replacement
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Malignant Hypothermia
- ☐ Mental Health Disorder
- ☐ Mitral Valve Prolapse
- ☐ Organ Transplant
- ☐ Osteoporosis Medications
- ☐ Pacemaker'
- ☐ Rheumatic Fever
- ☐ Seizure (Epilepsy)
- ☐ Shortness of Breath
- ☐ Steroid Therapy
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ No Medical Concerns
- ☐ Other: _____

Please list any medications (with dosage), supplements, or vitamins you are currently taking:

_____

_____

Are you allergic to any of the following:

- Penicillin
- Codeine
- Aspirin (ASA)
- Local Anesthetic
- Sulfa Drugs
- Latex
- Other
- No known allergies or reactions

If you chose **other,** please list what you are allergic to:

_____

_____

_____

_____

Have you ever had a serious illness or operation? ☐ Yes ☐ No

Have you been hospitalized in the last 2 years? ☐ Yes ☐ No

If **yes**, please explain: _____

Date of last medical checkup: _____

Any changes in your health in the past year? ☐ Yes ☐ No

If **yes,** please explain: _____

Have you been advised by your doctor to take pre-medications prior to dental treatment? ☐ Yes ☐ No

For Women

Are you pregnant? ☐ Yes ☐ No

When is your due date? _____

Are you currently breastfeeding? Yes ☐ No ☐

Insurance Information

1st Insurance Co: Name of insured: DOB: Group/Plan No. ID#

2nd Insurance Co: Name of insured: DOB: Group /Plan No. ID#

When was your last dental checkup & cleaning? _____

Do you have any dental concerns now? _____

Do you grind your teeth and/or have TMJ problems? ☐ Yes ☐ No

Are you interested in: ___ Whitening ___ Invisalign/Clear Aligners ___ None

Rate the importance of your dental treatment
1 is **most important** and 4 being **least important**

___ Functionality ___ Cost ___ Cosmetic ___ Longevity

Have you ever experienced any complications after dental surgery? ☐ Yes ☐ No

Do have any of the following appliances:

- ☐ Nightguard
- ☐ Retainers
- ☐ CPAP Machine
- ☐ Complete Denture
- ☐ Partial Denture
- ☐ Snore Appliance

How do you rate yourself as a patient? ___ Calm ___ Slightly Nervous ___ Very Nervous

Patient Certification and Consent

I, as the undersigned, certify that all the above medical and dental information is true to the best of my knowledge. I agree to the performing of dental and oral surgery procedures as described to be necessary/advisable. This includes the use of local anesthetics or other prescribed medications as indicated. I understand that these procedures are diagnosed based on my personal dental needs. Any procedures that are performed, and the fees associated with are fully my responsibility. I agree with the policies and procedures of the practice. I consent to the electronic sharing of my personal data with my dental benefit carrier and any third-party specialist offices for the purposes of processing claims and the determination of benefits. My dental benefit policy is a contract between myself and the insurer not between the insurer and my dental practitioner. I authorize the dental team of Creekside Dental Care to provide me with professional dental services. I understand that photographs may be taken for medical, educational, or research purposes. I hereby consent to the use of such photographs. I have been advised that Creekside Dental Care requires 24 business hours' notice to make changes to existing appointments, otherwise I may be subject to a **$50** broken appointment fee – depending on emergency and unforeseen circumstances.

_____ _____

Patient Signature Date Signed