NOVA DENTAL

Patient Full Name:_____ Sex: ☐M ☐F

Date of Birth:_____

Home Address: _____

City:_____ State:_____ Zip: _____

Home Ph: _____ Cell Ph: _____ Work Ph: _____

Email: _____

In case of emergency:

Contact:_____ Relationship:_____ Ph: _____

Insurance Information:
Please present **ALL** dental insurance information prior to being seen by our office. Present card(s) and a valid photo ID. You are responsible for providing all current insurance information prior to any dental appointment.

Responsible Party: (IF PATIENT IS UNDER 18 YEARS OLD) please complete each line

Name of person responsible for this account:_____ Relationship: _____

Address: _____

Home Ph: _____ Cell Ph: _____ Work Ph: _____

DOB:_____ SSN: _____

Employer:_____ Current Patient: Yes No

DENTAL HEALTH HISTORY
Confidential

Today's Date: _____

Patient Name: _____ Birthdate: _____
Last First Initial

DENTAL HISTORY

Reason for Today's visit: _____ Date of last dental care: _____

Former Dentist: _____ Date of last dental x-rays: _____

Address: _____

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

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

How often do you floss: _____ How often do you brush: _____

MEDICAL HISTORY

Physician's Name: _____ Date of last visit: _____

Have you had any serious illnesses or operations: _____ If yes, describe _____

Have you ever had a blood transfusion: ☐ Yes ☐ No If yes, give approx. date _____

Have you ever taken and of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (Phentermine), Pondimin (Fenfluramine) and Redux (Dexfenfluramine). ☐ Yes ☐ No

Are you pregnant: ☐ Yes ☐ No Months: _____ Nursing? ☐ Yes ☐ No

Taking birth control pills: ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

☐ Currently taking blood thinner
☐ ADD/ADHD/Autism
☐ Acid Reflux/GERD
☐ Anemia (Iron deficiency)
☐ Arthritis
☐ Depression
☐ STI/STD/HPV
☐ Autoimmune Disease
☐ Artificial heart valve
☐ Pacemaker/Defibrillator
☐ Orthopedic Implant (joint replacement)
☐ High or Low blood pressure
☐ Stroke/Heart Attack
☐ Tuberculosis, measles, chicken pox
☐ Asthma
☐ Liver Disease
☐ Thyroid Disease
☐ Hormone Deficiency
☐ High Cholesterol
☐ Diabetes type: A or B
☐ Stomach Ulcer
☐ Digestive or eating disorder
☐ Osteoporosis/Osteopenia

specify: _____

when: _____

when: _____

type: _____

☐ Contact lenses
☐ Glaucoma
☐ Head or neck injuries
☐ Epilepsy, convulsions/seizures
☐ Cold/canker sores
☐ Hepatitis type: A B C
☐ HIV/AIDS
☐ Cancer type: _____
☐ Radiation therapy
☐ Chemotherapy
☐ Emotional difficulties
☐ Psychiatric treatment
☐ Antidepressant medication
☐ Alcohol Abuse
☐ Drug Abuse
☐ Marijuana Use
☐ Smoker (current or prior)
☐ Breathing Problems type: _____
☐ Sleeping Problems/Snoring
☐ Clench/Grind Teeth
☐ Vaping
☐ Kidney Disease
☐ Other Illness not listed

MEDICATIONS

List medications you are currently taking (prescription, over-the-counter, vitamins, herbal): _____

ALLERGIES

☐ Aspirin ☐ Acrylic ☐ Barbiturates (sleeping pills) ☐ Codeine ☐ Local Anesthetic ☐ Penicillin
☐ Sulfa ☐ Latex ☐ Other_____

Consent for Treatment
I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in medical, personal, or insurance status. I hereby authorize the dental staff to perform any necessary dental services required during diagnosis and treatment, with my informed consent. I understand that there are certain risks inherent in dental treatment; such as but not limited to: pulpal sensitivity or damage, tissue swelling or damage, soreness of jaw, paresthesia and other procedure specific risks.

Insurance Release and Responsibility for Payment
I authorize release of information regarding my dental treatment to my insurance carrier. I agree to be responsible for payment on services rendered during any ineligible insurance period and any balance not covered by my insurance carrier.

Missed Appointment Policy
When a patient misses an appointment without giving prior notice, this treatment time is lost, preventing someone else in need of care from receiving treatment. In order to provide our patients with the highest quality dentistry, as well as accept new patients with urgent dental needs, it is important to minimize the number of no-show and rescheduled appointments. As a result, we have adopted the following policy regarding appointment cancellations: If a patient must reschedule an appointment, it is necessary that we receive 24 hours advance notice. If you are too late for your scheduled appointment time, you may not be able to be seen, resulting in a broken appointment. Any patient who has broken 2 appointments with in a 12 month period may lose the opportunity to be able to receive further care in our office. I understand that I may be charged for any broken appointment without 24 hours notice. The office has the right to dismiss me from the practice with continued broken appointments without 24 hours notice.

SIGNATURE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____
Signature of Patient, Parent, Guardian Date

_____ _____
Please print name of Patient, Parent, Guardian Relationship to Patient