NORTHWEST SMILE DESIGN
KELLY B. PETERSON, D. D. S.

New Patient Information Form

Personal Information

Today's Date_____/_____/_____
Patient Name: _____
LAST FIRST MI
Preferred Name: _____ ☐ Male ☐ Female
Birth Date: _____/_____/_____SSN: _____
Mailing Address: _____

_____
CITY STATE ZIP
Home Phone # (_____)_____
Work Phone # (_____) _____ Ext: _____
Cell Phone # (_____)_____
E-Mail Address:_____
Referred By:_____
Employer: _____ How Long? _____
Employer's Address: _____

_____
CITY STATE ZIP
Occupation:_____
Status: ☐Minor ☐Single ☐Married ☐Divorced ☐Separated ☐ Widowed
Spouse's Name:_____
Do you have children? ☐ No ☐ Yes How Many? _____

Account Information

Person Ultimately Responsible for Account

Name:_____
Relation:_____
Billing Address: _____

_____
CITY STATE ZIP
SSN: _____DOB:____/_____/_____
Drivers License #: _____
Work Phone: _____

_____ I hereby authorize assignment of my insurance rights and benefits directly to Northwest Smile Design for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.
Initials

Insurance Information

Primary Dental Insurance
Company Name:_____
Address: _____

_____
CITY STATE ZIP
Phone #: (_____)_____
Insured's ID or SSN:_____
Group # (Plan, Local, or Policy #) _____
Insured's Name:_____
Relationship: _____
Insured's Employer:_____

Secondary Dental Insurance
Company Name:_____
Address: _____

_____
CITY STATE ZIP
Phone #: (_____)_____
Insured's ID or SSN:_____
Group # (Plan, Local, or Policy #) _____
Insured's Name:_____
Relationship: _____
Insured's Employer:_____

In Event of Emergency

Whom Should we contact?_____
Relation: _____ Phone # _____
Medical Dr:_____ Phone #_____

Dental History

Reason for today's visit: □ Exam □ Emergency □ Consultation

Are you in pain? □ No □ Yes How Long? _____

Please indicate √ any of the following problems:

- □ Discomfort, clicking or popping in jaw
- □ Lost/Broken filling(s)
- □ Stained teeth
- □ Red, swollen or bleeding gums
- □ Blisters/sores in or around mouth
- □ Sensitive tooth, teeth or gums
- □ Teeth grinding
- □ Locking jaw
- □ Ringing in ears
- □ Bad breath
- □ Broken/Chipped tooth
- □ Other_____

Do you require pre-medication? □ No □ Yes □ Don't know

Previous Dentist: _____ (___) _____

Name Phone #

Last Dental Exam: _____/_____/_____ Last Dental X-rays _____/_____/_____

Times a day you brush? _____ Times a week you floss? _____

What type of tooth brush do you use? □ Soft □ Medium □ Hard

How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

Medical History

Are you taking any medications? □ No □ Yes If yes, please list:_____

_____

_____

Do you have or have you had any of the following diseases, medical conditions, or procedures?

Y N Heart Attack, Stroke	**Y N** Thyroid Problems	**Y N** Cancer/Tumors	**Y N** Cosmetic Surgery
Y N Heart Surg./Pacemaker	**Y N** Kidney Problems	**Y N** Shingles	**Y N** X-ray/Cobalt Treatment
Y N Heart Murmur	**Y N** Liver Problems	**Y N** Hepatitis	**Y N** Chemotherapy
Y N Rheumatic Fever	**Y N** Respiratory Problems	**Y N** HIV+/AIDS/ARC	**Y N** Asthma
Y N Mitral Valve Prolapse	**Y N** Sinus Problems	**Y N** Arthritis, Rheumatism	**Y N** Difficulty Breathing
Y N Artificial Valves	**Y N** Stomach Problems	**Y N** Emphysema	**Y N** Diabetes/Hypoglycemia
Y N Heart Disease	**Y N** Psychiatric Problems	**Y N** Fainting/Seizures/Epilepsy	**Y N** Leukemia
Y N Congenital Heart Defect	**Y N** Venereal Disease	**Y N** Artificial Bones/Joints	**Y N** Anemia
Y N Chest Pains	**Y N** Alcohol/Drug Abuse	**Y N** Severe/FrequentHeadaches	**Y N** High/Low Blood Pressure
Y N Scarlet Fever	**Y N** Tuberculosis TB	**Y N** Frequent Neck Pain	**Y N** Bleeding Problems
Y N Nervousness	**Y N** Jaw Problems TMJ	**Y N** Back Problems	**Y N** Glaucoma

Please list any other surgeries or medical conditions you have or ever had:_____

_____

Are you allergic to any of the following? □ Latex □ Penicillin/Amoxicillin □ Tetracycline □ Aspirin □ Dental Anesthetics □ Others: _____

Do you use tobacco? □ No □ Yes/How used? _____ How much? _____ How long? _____

Please rate your general health from 1-10: _____ Do you wear contact lenses? □ Yes □ No

For women: Are you taking Birth Control pills? □ Yes □ No How many children have you had?____

Are you pregnant? □ No □ Yes/How long?_____ Are you nursing? □ Yes □ No

- We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no written financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature_____ Date_____

□ Adult Patient □ Parent/Guardian □ Spouse