



**New Patient Information**

Name \_\_\_\_\_  
Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ Prov. \_\_\_\_ PC \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_  
Email \_\_\_\_\_  
How did you hear about our office?  
\_\_\_\_\_

Emergency Contact  
\_\_\_\_\_

Phone \_\_\_\_\_  
Name of previous dental office  
\_\_\_\_\_

When was the last exam and hygiene visit?  
\_\_\_\_\_

**Responsible Party/Guardian**

Name of person responsible for account  
\_\_\_\_\_

Relationship to patient \_\_\_\_\_  
Cell Phone \_\_\_\_\_

**Insurance Information**

**Dental History**

Do your gums bleed during brushing/ flossing? Y/N  
Are your teeth sensitive to hot/ cold/ sweet/ sour? Y/N  
Do you have any pain in your teeth? Y/N  
Do you have any sores or lumps in or near your mouth? Y/N  
Have you had any head, neck, or jaw injuries? Y/N  
Do you grind or clench your teeth? Y/N  
Do you experience any Jaw Clicking, Pain, Difficulty Chewing, Migraines or Headaches? Y/N  
Do you bite your lips or cheeks? Y/N  
Have you ever had difficult extractions? Y/N  
Have you had prolonged bleeding following extractions? Y/N  
Have you had orthodontic treatment? Y/N  
Do you wear dentures or partials? If yes, for how long? Y/N  
Have you received oral hygiene instruction regarding the care of your teeth and gums? Y/N

***Primary***

Name of Insured  
\_\_\_\_\_  
Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_  
Relationship to Patient  
\_\_\_\_\_  
Name of Insurance Company  
\_\_\_\_\_  
Group # \_\_\_\_\_ Division # \_\_\_\_\_  
ID # \_\_\_\_\_

***Secondary***

Name of Insured  
\_\_\_\_\_  
Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_  
Relationship to Patient  
\_\_\_\_\_  
Name of Insurance Company  
\_\_\_\_\_  
Group # \_\_\_\_\_ Division # \_\_\_\_\_  
ID # \_\_\_\_\_

\*\*As per our office policies, we do require payment in full upfront at each appointment. We will however, submit to the insurance company on your behalf, and they will reimburse you directly.

-----Convenience Close to Home-----

Dr. Arun Bakhshi    Dr. Kenny Gryckiewicz    Dr. Jaiminkumar Patel



## Medical History

Physician \_\_\_\_\_ Phone Number \_\_\_\_\_ Last Checkup \_\_\_\_\_

Are you under medical treatment now?

Are you taking prescription or non-prescription medications? If yes, please list the medications.

Have you been hospitalized for any reason in the last 5 years? If yes, please explain.

Do you use controlled or recreational substances?

### **Women Only:**

Are you/do you think you may be pregnant? Y/N

Are you taking oral contraceptives? Y/N

Are you nursing/breastfeeding? Y/N

Please Check ALL **Medical Conditions** You Currently Have or Previously Had.

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Dental Anxiety           | <input type="checkbox"/> Chest Pain/Angina       | <input type="checkbox"/> Liver Failure           |
| <input type="checkbox"/> Severe Gag Reflex        | <input type="checkbox"/> Easily Winded           | <input type="checkbox"/> Undiagnosed Rash        |
| <input type="checkbox"/> Osteoporosis             | <input type="checkbox"/> Frequently Tired        | <input type="checkbox"/> Lupus                   |
| <input type="checkbox"/> Bisphosphonate Use       | <input type="checkbox"/> Bruise Easily           | <input type="checkbox"/> Arthritis               |
| <input type="checkbox"/> Diabetes Type 1          | <input type="checkbox"/> Blood Thinners          | <input type="checkbox"/> Rheumatoid Arthritis    |
| <input type="checkbox"/> Diabetes Type 2          | <input type="checkbox"/> DVT or Blood Clot       | <input type="checkbox"/> Addison's Disease       |
| <input type="checkbox"/> Hemophilia A or B        | <input type="checkbox"/> Autism                  | <input type="checkbox"/> Adrenal Insufficiency   |
| <input type="checkbox"/> Von Willebrand Disease   | <input type="checkbox"/> Epilepsy                | <input type="checkbox"/> Chron's Disease         |
| <input type="checkbox"/> Heart Valve Replacement  | <input type="checkbox"/> Seizure                 | <input type="checkbox"/> Ulcerative Colitis      |
| <input type="checkbox"/> Atrial Fibrillation      | <input type="checkbox"/> Parkinsons              | <input type="checkbox"/> Celiac Disease          |
| <input type="checkbox"/> Cardiac Ablation         | <input type="checkbox"/> Dementia                | <input type="checkbox"/> COPD                    |
| <input type="checkbox"/> Cardiac Stent            | <input type="checkbox"/> ALS                     | <input type="checkbox"/> Asthma                  |
| <input type="checkbox"/> Arrhythmia               | <input type="checkbox"/> Multiple Sclerosis      | <input type="checkbox"/> Emphysema               |
| <input type="checkbox"/> Aneurysm                 | <input type="checkbox"/> Brain Surgery           | <input type="checkbox"/> Oxygen Tank             |
| <input type="checkbox"/> Pacemaker                | <input type="checkbox"/> MuscularDystrophy       | <input type="checkbox"/> Sleep Apnea             |
| <input type="checkbox"/> Cardiac Bypass Surgery   | <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Hashimoto's Thyroiditis |
| <input type="checkbox"/> Mitral Valve Prolapse    | <input type="checkbox"/> Chemo Therapy           | <input type="checkbox"/> Hyperthyroidism         |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Radiation Therapy       | <input type="checkbox"/> Hypothyroidism          |
| <input type="checkbox"/> Heart Attack             | <input type="checkbox"/> Leukemia                | <input type="checkbox"/> Glaucoma                |
| <input type="checkbox"/> Cardiac Arrest           | <input type="checkbox"/> Lymphoma                | <input type="checkbox"/> Recent weight loss      |
| <input type="checkbox"/> Stroke                   | <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Lymphedema              |
| <input type="checkbox"/> Pulmonary Disease        | <input type="checkbox"/> Bone Marrow Transplant  | <input type="checkbox"/> Renal Failure           |
| <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Organ Transplant        | <input type="checkbox"/> Kidney Transplant       |
| <input type="checkbox"/> Low Blood Pressure       | <input type="checkbox"/> Acid Reflux/ Heart Burn | <input type="checkbox"/> Kidney Removal          |
|   | <input type="checkbox"/> Ulcers                  | <input type="checkbox"/> Dialysis                |
|   | <input type="checkbox"/> Tuberculosis            | <input type="checkbox"/> Wheelchair or Walker    |
|   | <input type="checkbox"/> STD                     | <input type="checkbox"/> Vertigo                 |
|   | <input type="checkbox"/> HIV/AIDS                | <input type="checkbox"/> Other _____             |
|   | <input type="checkbox"/> Hepatitis A or E        |  |
|   | <input type="checkbox"/> Hepatitis B or C        |  |

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## **Allergies**

Are you **allergic to or have you had any** reactions to:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Latex              | <input type="checkbox"/> Toradol           | <input type="checkbox"/> Peanuts         |
| <input type="checkbox"/> Sulfa Drugs        | <input type="checkbox"/> Steroids          | <input type="checkbox"/> Shellfish       |
| <input type="checkbox"/> Penicillin         | <input type="checkbox"/> Aspirin           | <input type="checkbox"/> Iodine          |
| <input type="checkbox"/> Clindamycin        | <input type="checkbox"/> Local Anesthetics | <input type="checkbox"/> NSAIDS          |
| <input type="checkbox"/> Codeine            | <input type="checkbox"/> Sedative          | <input type="checkbox"/> Adhesives       |
| <input type="checkbox"/> General Anesthetic | <input type="checkbox"/> Metals            | <input type="checkbox"/> Artificial Dyes |

Other (Please list) \_\_\_\_\_

## **Authorization and Release**

I certify that I have read and understand the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and or health practitioners.

## **Cancellation & Credit Card Policy**

As per our office policy, we do require 2 business days notice to change or cancel any appointments. Cancellations without the proper notice may be subject to a **\$75.00 fee**. Not showing up for a confirmed appointment will be subject to a **\$100.00 fee**. All patients are required to keep a **valid credit card on file** for any outstanding amounts owing.

I agree to and understand the office policies of Coach Hill Dental.

(Signature) \_\_\_\_\_ (Date) \_\_\_\_\_

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