COACH HILL DENTAL

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

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.

Dental History

1. Do your gums bleed during brushing/ flossing? Y/N
2. Are your teeth sensitive to hot/ cold/ sweet/ sour? Y/N
3. Do you have any pain in your teeth? Y/N
4. Do you have any sores or lumps in or near your mouth? Y/N
5. Have you had any head, neck, or jaw injuries? Y/N
6. Do you grind or clench your teeth? Y/N
7. Do you experience any Jaw Clicking, Pain, Difficulty Chewing, Migraines or Headaches? Y/N
8. Do you snore or have sleep apnea? Y/N
9. Are you interested in improving your smile aesthetics? Y/N
    a. Are you open to orthodontics to correct your bite/smile? Y/N
    b. Are you open to gum surgery/procedures to correct your smile? Y/N
10. Have you had orthodontic treatment? Y/N
11. Do you wear dentures or partials? If yes, for how long? Y/N
12. Have you ever used Tobacco Products? Y/N

COACH HILL DENTAL

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.

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

COACH HILL DENTAL

Allergies

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

□ Latex	□ Toradol	□ Peanuts
□ Sulfa Drugs	□ Steroids	□ Shellfish
□ Penicillin	□ Aspirin	□ Iodine
□ Clindamycin	□ Local Anesthetics	□ NSAIDS
□ Codeine	□ Sedative	□ Adhesives
□ General Anesthetic	□ Metals	□ 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 48 business hours 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** at all times for any outstanding amounts owing.

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

(Signature) _____ (Date)_____