New Patient Forms

BDG BEDFORD DENTAL GROUP

PATIENT INFORMATION

☐ Mr. ☐ Miss ☐ Mrs.	LAST NAME FIRST MIDDLE	SEX: ☐ M ☐ F	☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED
HOME ADDRESS CITY STATE ZIP		BIRTHDAY	AGE
EMAIL	CELL PHONE ( )	HOME TELEPHONE ( )	
PATIENT S.S #	DRIVERS LIC. #		

EMPLOYER INFORMATION

OCCUPATION	EMPLOYER	
EMPLOYER ADDRESS CITY STATE ZIP		WORK PHONE ( )

FINANCIAL RESPONSIBILITY

NAME OF FINANCIALLY RESPONSIBLE PARTY	NAME OF INSURANCE PLAN	GROUP #:	ID #
GROUP #	INSURED S.S. #	BIRTH DATE OF INSURED	

HOW DID YOU HEAR ABOUT US?

DENTAL HISTORY

Reason for today's visit _____

Are you currently in pain? _____

Date of last dental care & X-Rays _____ Date of last cleaning _____

Do you have any amalgam (metal) fillings? _____ If yes, how many? _____

Have you had any amalgam fillings and had them removed? _____ When? _____

Do you have any root canal? _____ If yes, how many? _____ How old? _____

Have you had any gold crowns or fillings? _____ If yes, how many? _____

Have you had oral cancer screening? _____

How often do you floss? _____

How often do you brush? _____

Symptoms

- ☐ bad breath
- ☐ bleeding gums
- ☐ clicking or popping jaw
- ☐ food collection between teeth
- ☐ grinding teeth
- ☐ periodontal treatment
- ☐ sensitive to cold or hot
- ☐ sensitive to sweet
- ☐ yellow & discolored teeth
- ☐ loose teeth or broken filling

Please Sign _____

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MEDICAL HISTORY

YES NO		YES NO		YES NO	
☐ ☐	Are you pregnant	☐ ☐	Kidney or Liver Disease	☐ ☐	Cancer
☐ ☐	Angina	☐ ☐	Hepatitis	☐ ☐	Prolonged Bleeding
☐ ☐	High Blood Pressure	☐ ☐	Thyroid Disorder	☐ ☐	Bleeding Problems
☐ ☐	Heart Murmur	☐ ☐	Been on Fen Fen	☐ ☐	Syphilis
☐ ☐	Defective Heart Valve	☐ ☐	Seizures	☐ ☐	Gonorrhea
☐ ☐	Pacemaker	☐ ☐	Fainting or Dizziness	☐ ☐	AIDS / HIV+
☐ ☐	Heart Trouble	☐ ☐	Rheumatoid Arthritis	☐ ☐	Herpes
☐ ☐	Mitral Valve Prolapse	☐ ☐	Tuberculosis	☐ ☐	Artificial Joints
☐ ☐	Diabetes	☐ ☐	Blood Disease	☐ ☐	Trouble falling asleep at night
☐ ☐	Rheumatic Fever	☐ ☐	Anemia	☐ ☐	Sleep apnea
☐ ☐	Asthma, Breathing Problem	☐ ☐	Frequent Headaches	☐ ☐	Snore at night

Are you allergic to:

☐ Local Anesthetic ☐ Aspirin ☐ Codeine ☐ Latex
☐ Erythromycin ☐ Penicillin ☐ Sulfa ☐ Other _____

Drugs presently taking _____

Family Physician _____ Phone # _____

Please list any other health or dental condition we should be aware of: _____

Have you been under a physician's care during the past 2 years?

☐ No ☐ Yes (please describe) _____

I have read the above questionnaire in its entirety and have answered all questions truthfully to the best of my knowledge. I hereby authorize the dentist(s) in charge to perform any and all treatment for my child or myself (if patient is minor). I also consent to such methods as x-rays, drugs, and agents as may be indicated in connection with treatment. The consent will remain in effect until cancelled. I hereby authorize payment directly to Dr. M. Nayssan and/or Dr. D. Naysan, of the group insurance benefits unless other written arrangements have been mane prior to treatment. I understand that I am financially responsible for the charges not covered by my insurance plan. I hereby authorize release of any information relating to mysel or dependent child, to be shared with any facility in order to obtain benefits and/or payment. I also understand that payment is expected for service rendered at this office upon the first visit. In the event, payments are not received by the agreed upon dates, I understand that 1.5% finance charge (18% APR) may be added to my balance, in addition to any collection charges or legal fees. I also understand that I will be charged a fee of $50.00 at this facility should I not notify this office of my cancellation without a 24 hour notice.

Date:_____ Signature: _____ Dentist: _____

YEAR 2 UPDATE **DATE** _____
___ The above health history is true & accurate
___ I have had following changes in my health/ medication:

Pt._____ Dr. _____

YEAR 3 UPDATE **DATE** _____
___ The above health history is true & accurate
___ I have had following changes in my health/ medication:

Pt. _____ Dr. _____