BON EWERT, DDS, PC
comprehensive family dental care
"We care for your smile"

New Patient Information Form

Today's Date: ______________ Email: ____

Patient Name: ____________________ ________________________ ____ I prefer to be called: ____________ ___ Male ___ Female
Last First MI

Birthdate: ___________ Age: ____ SS #: ________________ ___Single ___Married ___Divorced ___Widowed ___ Separated

Home Address: ____ ___________________________ ______________ ________________
City State Zip

Hm #: _______________ Pager/Cell #: __________________ Wk #: _______________ Ext: ____ DL#: ________________________

Employer: ____

Employer's Address: ____

How long there? _____ Occupation: ___________________ Where & when are best times to reach you? ________________________

Whom may we *Thank* for referring you? ___________________ Other family members seen by us: ______________________________________

Previous / Present Dentist: _____________________________ Last Visit Date: _______________________________

Spouse Information

His / Her Name: _____________________________________ Employer: ____

Wk #: ____________ Ext: ___ SS #: ______________________ Birthdate: _____________ DL #: _________________________

Person Responsible for Account

His / Her Name: ____ Wk #: _______________ Ext: ___ Hm #: ________________

Billing Address: ____

Relation: ________________ Employer: _____________________________________ DL #: ________________ SS #: ______________________

Primary Dental Insurance

Insurance Co. Name: ______________________________ Address: ____

Insurance Co. Phone #: _______________________ Group # (Plan, Local or Policy #): ______________________________________

Insured's Name: ____________________________________ Relation to Patient: ________________ Insured's Birthdate: ______________

Insured's ID #: ______________________ Insured's Employer: ____

Secondary Dental Insurance

Insurance Co. Name: ______________________________ Address: ____

Insurance Co. Phone #: _________________________ Group # (Plan, Local or Policy #): ______________________________________

Insured's Name: ____________________________________ Relation to Patient: ________________ Insured's Birthdate: ______________

Insured's ID #: ______________________ Insured's Employer: ____

Employer's Address: ____

Emergency Contact

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her Name: ____ Relation: ____

Wk #: ________________ Ext: ____ Hm #: _____________________

Medical History

Do you have a personal physician? ___ Yes ___ No If yes, Physician's Name: ______________________________________

Are you currently under the care of a physician? ___ Yes ___No Please Explain: ____

Physician's Phone #: ______________________ Date of Last Visit: __________________

Your current physical health is: ___ Good ___ Fair ___ Poor Do you smoke or use tobacco in any other form? ___ Yes ___ No

Are you taking any prescription / over-the-counter or supplement drugs? ___ Yes ___ No

Please list each one: ____

Have you ever taken Phen-Fen? (Also known as Redux or Pondimin) ___ Yes ___ No If so, when? ___________________________

For Women: Are you using a prescribed method of birth control? ___ Yes ___ No

Are you pregnant? ___ Yes ___ No Week #: ___________ Are you nursing? ___ Yes ___ No

Have you ever had any of the following disease or medical problems? (Please check those that apply)

___Y ___ N **Anemia / Radiation Treatment**
___Y ___ N **Artificial Bones / Joints / Valves**
___Y ___ N **Arthritis**
___Y ___ N **Asthma**
___Y ___ N **Blood Transfusion**
___Y ___ N **Cancer / Chemotherapy**
___Y ___ N **Congenital Heart Defect**
___Y ___ N **Diabetes**
___Y ___ N **Difficulty Breathing**
___Y ___ N **Drug / Alcohol Abuse**
___Y ___ N **Emphysema / Glaucoma**
___Y ___ N **Epilepsy / Seizures / Fainting Spells**
___Y ___ N **Fever Blisters / Herpes**
___Y ___ N **Heart Attack / Stroke**
___Y ___ N **Heart Murmur**
___Y ___ N **Heart Surgery / Pacemaker**
___Y ___ N **Hemophilia / Abnormal Bleeding**
___Y ___ N **Hepatitis**
___Y ___ N **High / Low Blood Pressure**
___Y ___ N **HIV+ / AIDS**
___Y ___ N **Hospitalized for Any Reason**
___Y ___ N **Kidney Problems**
___Y ___ N **Mitral Valve Prolapse**
___Y ___ N **Psychiatric Problems**
___Y ___ N **Rheumatic / Scarlet Fever**
___Y ___ N **Severe / Frequent Headaches**
___Y ___ N **Shingles**
___Y ___ N **Sickle Cell Disease / Traits**
___Y ___ N **Sinus Problems**
___Y ___ N **Tuberculosis (TB)**
___Y ___ N **Ulcers / Colitis**
___Y ___ N **Venereal Disease**

Please list any serious medical condition(s) that you have ever had: ____

____

Are you allergic to any of the following?

___Y ___ N **Aspirin** ___Y ___ N **Erythromycin** ___Y ___ N **Penicillin** ___Y ___ N **Codeine**
___Y ___ N **Jewelry / Metals** ___Y ___ N **Tetracycline** ___Y ___ N **Latex** ___Y ___ N **Dental Anesthetics**
___Y ___ N **Other**

Please list any other drugs / materials that you are allergic to: ____

____

Dental History

Why have you come to the dentist today? ____

Do you require antibiotics before dental treatment? ___ Yes ___ No Are you currently in pain? ___ Yes ___ No

Have you ever had a serious / difficult problem associated with any previous dental work? ___ Yes ___ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ___ Yes ___ No

Your current dental health is: ___ Good ___ Fair ___ Poor Do you like your smile? ___ Yes ___ No

Do your gums ever bleed? ___ Yes ___ No Have you ever had periodontal disease? ___ Yes ___ No

How many times per week to you floss? ______ a day or do you brush? _________ Type of bristles? ___ Hard ___ Medium ___ Soft

I understand that the information that 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 it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

____

Signature Date

Thank you for filling out this form completely. It will enable us to help you more effectively. **You may print this form out and mail it to us, signed, or you may submit it online and sign it on your first visit.** If you have questions at any time, please ask us. We are happy to help.

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials __________ Date: _________

Doctor's Comments: ____

____

MEDICAL HISTORY UPDATE

1. **Date:** __________ **Comments:** ______________________ **Signature:** ______________
2. **Date:** __________ **Comments:** ______________________ **Signature:** ______________
3. **Date:** __________ **Comments:** ______________________ **Signature:** ______________

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