iSmile
FAMILY DENTISTRY
Dr. Gunita Singh, DDS

Today's date:	PCP:

NEW PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Dr. ❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

How did you hear about us?

Other family members seen here:

EMAIL:

INSURANCE/FINANCIAL INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. Singh to release any information required to process my claims.

Patient/Guardian signature *Date*

MEDICAL HISTORY

NAME:

Are you in good health? ❑ Yes ❑No	Have you had a serious illness, operation or been hospitalized in the last 5 years?
Physician Name:	
Phone: ( )	
Date of last physical exam:	

Please list all **medications** (prescription and over the counter), vitamins and diet/herbal supplements you are taking **(you can also provide a copy of medications)**

Drug	Dose/ Frequency	Reason

Please mark (X) your response to indicate if you have or have not had any of the following diseases:

	Y	N		Y	N		Y	N
Cardiovascular disease			AIDS/HIV infection			Hepatitis, jaundice or liver disease		
Angina			Arthritis			Epilepsy		
Arteriosclerosis			Autoimmune disease			Seizures		
Congestive Heart failure			Rheumatoid arthritis			Neurological disorders Specify (if yes):		
Damaged heart valves			Lupus			Sleep disorder		
Heart attack			Asthma			Mental health disorder Specify (if yes):		
Heart murmur			Bronchitis			Recurrent infections: Type of infection:		
Low blood pressure			Emphysema			Kidney Problems		
High blood pressure			Sinus trouble			Night sweats		
Other congenital heart defects			Tuberculosis			Osteoporosis		
Artificial (prosthetic) heart valve			Cancer			Persistent swollen glands in neck		
Previous infective endocarditis			Chemotherapy or Radiation treatment			Severe headaches/migraines		
Damaged valves in transplanted heart			Chest pain upon exertion			Severe or rapid weight loss		
Congenital heart disease (CHD) **Unrepaired, cyanotic CHD** **Repaired (completely)last 6 mo** **Repaired CHD with residual defects**			Chronic pain If yes, what type: _____ _____			Has a physician or previous dentist recommended that you take antibiotics prior to you dental treatment? If yes, for what reason:		
Mitral valve prolapses			Diabetes Type I or II			Excessive urination		
Pacemaker			Eating Disorder			Sexually transmitted disease		
Rheumatic fever			Malnutrition			Smoking: (if yes, pack/day:)		
Rheumatic heart disease			Gastrointestinal disease			Do you use controlled substances:		
Abnormal Bleeding			G.E reflux/ heartburn			Do you take oral/IV bisphosphonates such as Fosamax, Actonel, Aredia, Zometa for bone pain, hypercalcemia, Paget's disease:		
Anemia			Ulcer					
Blood transfusion			Thyroid Disease					
Hemophilia			Glaucoma					

WOMEN ONLY: are you pregnant? ❑NO ❑YES, how many weeks? Nursing? ❑Yes ❑No
Are you taking birth control or hormonal replacement?

ALLERGIES: ❑Antibiotics (eg. Penicillin), if so which one?
❑Latex ❑Dental Anesthetics ❑Food ❑Aspirin ❑Anti-inflammatories ❑Sulfa Drugs ❑Codeine or other narcotics ❑Metals ❑Hay fever/ seasonal ❑Barbiturates, sedatives ❑Other allergies:

Joint Replacement: have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ❑Yes ❑No ❑DK. If Yes, which date?

Any medication condition that is not listed:

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Patient/Guardian signature *Date*

Dental History					
	Y	N		Y	N
Do your gums bleed when you brush or floss?			Do you have earaches or neck pains?		
Are your teeth sensitive to cold, hot, sweets or pressure?			Do you have any clicking, popping or discomfort in the jaw/		
Does food or floss catch between your teeth?			Do you brux or grind your teeth?		
Is your mouth dry?			Do you have sores or ulcers in your mouth?		
Have you had any problems associated with previous dental treatment?			Do you wear dentures or partials?		
Is your home water supply fluoridated?			Do you participate in active recreational activities/sports? Specify (if yes):		
Do you drink bottled or filtered water?			Have you ever had a serious injury to your head or mouth?		
Have you ever had orthodontic (braces) treatment?			Date of you last dental exam:		
Have you had any problems associated with previous dental treatment? Specify (if yes):			What was done:		
Are you currently experiencing dental pain or discomfort?			Date of last x-rays:		
What is your reason for your dental visit today?					
How do you feel about your smile?					

Acknowledgement of Receipt of Notice of Privacy Practices

*You May Refuse To Sign This Acknowledgement

!, _____, have viewed and read a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date