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NEW PATIENT INFORMATION

Patient Name: _____ Date: _____

Physical Address: _____
Street Apt # City State Zip

Mailing Address: _____
Street Apt # City State Zip

Best Way to Contact Me (Circle One): Home Phone / Cell Phone / Email / Work Phone

Phone Numbers:

Home: _____ Cell: _____ Work: _____

Birthdate: _____ Email: _____
Month / Day / Year

Place of Employment: _____ Social Security #: _____

*** PLEASE GIVE THE FRONT DESK YOUR INSURANCE CARD AT CHECK-IN ***

Insurance Company: _____

We will file your insurance once as a courtesy to you. If your insurance company does not pay within 60 days, you will be responsible for the remaining balance. It is ***your*** responsibility to provide us with accurate insurance information. If you do not, we cannot file your claim.

Primary Insured Name: _____

SS#: _____ Date of Birth: _____

I hereby authorize payment directly to Durango Family Dentistry of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment.

_____ _____
Patient's or Responsible Party's Signature Date

Person to Contact in Case of Emergency (Outside of Your Immediate Household):

Name: _____ Best Phone #: _____

Authorization for Treatment

I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medial histories and other information about my dental treatment to third party payers and/or professionals.

_____ _____
Patient's or Responsible Party's Signature Date

How did you hear about our practice:
□ "Free" Sign □ QwestDex (Yellow) □ Directory Plus (Red) □ Website □ Facebook □ Mailer
□ Radio _____ □ Friend _____ □ Other _____

What is the primary reason for this dental appointment:
□ Routine Exam □ Emergency □ Consultation

Do you have moderate to severe anxiety during dental procedure? Yes No
Have you been under a physician's care during the past two years? Yes No
If yes, for what reason: _____
_____
Have you taken any medication or drugs during the past two years? Yes No
Are you taking any medication, drugs or pills now, including regular doses of aspirin? (If yes, please list) Yes No
_____
_____
Have you ever taken prescription medication for weight loss? Yes No
Are you aware of having an allergic reaction to any medication? Yes No
Have you been a patient in the hospital during the last 5 years? Yes No

Indicate which of the following you have had, or have at present. (Circle yes or no to each item.)

Heart (surgery, disease, attack)	Yes	No	Ulcers	Yes	No
Chest pain	Yes	No	Diabetes	Yes	No
Congenital heart disease	Yes	No	Thyroid problems	Yes	No
Heart murmur	Yes	No	Glaucoma	Yes	No
High blood pressure	Yes	No	Emphysema	Yes	No
Mitral valve prolapse	Yes	No	Chronic cough	Yes	No
Artificial heart valve	Yes	No	Tuberculosis	Yes	No
Heart pacemaker	Yes	No	Asthma	Yes	No
Rheumatic fever	Yes	No	Hay fever	Yes	No
Arthritis / rheumatism	Yes	No	Latex sensitivity	Yes	No
Cortisone medicine	Yes	No	Allergies / hives	Yes	No
Swollen ankles	Yes	No	Sinus troubles	Yes	No
Stroke	Yes	No	Radiation therapy	Yes	No
Artificial joints (hip, knee)	Yes	No	Chemotherapy	Yes	No
Kidney trouble	Yes	No	Tumors	Yes	No
Hepatitis A, B, C	Yes	No	Venereal disease	Yes	No
AIDS	Yes	No	HIV positive	Yes	No
Cold sores / fever blisters	Yes	No	Blood transfusion	Yes	No
Hemophilia	Yes	No	Sickle cell disease	Yes	No
Bruise easily	Yes	No	Liver disease	Yes	No
Yellow jaundice	Yes	No	Neurological disorder	Yes	No
Epilepsy / seizures	Yes	No	Fainting / dizziness	Yes	No
Nevervousness / anxiety	Yes	No	Psychiatric care	Yes	No

Do you have any disease or condition not mentioned above? Yes No
If yes, please provide detail: _____
_____
Are you pregnant or nursing? Yes No
Are you allergic to any medication or substance? Yes No
If yes, please provide detail: _____
Are you allergic to: □ Aspirin □ Penicillin □ Codeine □ Acrylic □ Metal □ Latex Rubber

- We require 48 hours notice for cancellations and the rescheduling of appointments. Failure to comply may result in a $50.00 cancellation fee.
- The fee for a returned check is $25.00.

To the best of my knowledge, all the preceding answers are correct. If there are any changes in my health status or my medicines, I will inform the dentist and his staff at my next appointment.

Patient Name: _____ Date: _____

Patient/Guardian Signature: _____