

New Town Dental ArtsSM

SEBASTIANA SPRINGMANN, DDS

Patient Information

Date _____
 SS/HIC/Patient ID # _____
 Name _____

Address _____

City _____

State _____ Zip _____

E-mail _____

Home Phone _____ Cell Phone _____

Work Phone _____ ext _____

Occupation/Employer _____

Employer Address _____

SS#/SIN _____

DL# _____

Sex: M F Age _____

Birth-date: _____

- Married Widowed Single Separated
 Divorced Minor Partnered for _____ yrs

Who may we thank for referring you? _____

If Minor, Responsible Party Parent/Guardian Information?

Mother Father Legal Guardian

Name _____

Address _____

City _____

State _____ Zip _____

E-mail _____

Home Phone _____ Cell Phone _____

Work Phone _____ ext _____

Employer/Occupation _____

Employer Address _____

SS#/SIN _____

DL # _____

Sex: M F Age _____

Birth-date: _____

DENTAL INSURANCE

Who is responsible party for this account? _____

Relationship to Patient _____

Insurance Company _____

Group # _____ Account # _____

Subscriber's Name _____

Birth-date _____ SS# _____

Additional Insurance coverage/Company? _____

Relationship to Patient _____

Insurance Company _____

Group # _____ Account # _____

Subscriber's Name _____

Birth-date _____ SS# _____

Assignment and Release

I certify that I, and/or my dependents (s), have insurance coverage with _____ and assign directly to New Town Dental Arts

(Name of insurance company)

All insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

New Town Dental Arts may use my health care information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will be valid so long as I am a patient at New Town Dental Arts.

 Signature of Patient, Parent or Guardian or Personal Representative

 Please print Signature of Patient, Parent or Guardian or Personal Representative

Emergency Contact (someone who does not live in your household)

Name _____

Relationship _____

Home Phone _____

Cell Phone _____

Work Phone _____

Child's Physician _____ Phone _____

Previous Hospitalizations/surgeries/Serious Illnesses? _____

Dental History

Reason for today's visit _____

Former Dentist _____

Date of Last dental visit _____

Date of last x-Rays/Dental Image _____

Place a check on "yes or no" if you have any of the following:

- | | | |
|-----------------------------------|------------------------------|-----------------------------|
| Bad breath | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Bleeding gums | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Blisters on lips or mouth | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Burning sensation on tongue | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Chew on one side of mouth | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Cigarette, pipe, or cigar smoking | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Clicking or popping jaw | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Drink Bottled Water | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Dry mouth | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

- | | | |
|--------------------------------|------------------------------|-----------------------------|
| Fingernail biting | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Food collection between teeth | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Foreign objects | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Grinding/Clinching of teeth | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Gums swollen | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Jaw pain or tiredness | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Lip or cheek biting | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Loose teeth or broken fillings | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Mouth breathing | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Mouth pain, brushing | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Orthodontic treatment (braces) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Pain around ear | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Periodontal treatment (Gums) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Sensitivity to cold | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Sensitivity to heat | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Sensitivity to sweets | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Sensitivity when biting | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Smokeless Tobacco | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

- | | | |
|--------------------------------|------------------------------|-----------------------------|
| Sores or growths in your mouth | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Water Fluoridated?* | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Child Thumb sucking? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Child lip biting? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Child Chewing hard objects? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Child Grinding Teeth? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Child Clench Jaws? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Flossing frequency? _____ | | |
| Brushing frequency? _____ | | |

If minor, has your child had difficulty with previous dental exams? _____
 If yes, please explain _____

*Adult bottle water use? _____

Health History

Physician's Name _____ Date of Last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?"

These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine and Redux (dexfenfluramine)). YES NO

Place a mark on yes or no to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> YES <input type="checkbox"/> NO	GLAUCOMA	<input type="checkbox"/> YES <input type="checkbox"/> NO	SPECIAL DIET	<input type="checkbox"/> YES <input type="checkbox"/> NO
ARTHRITIS, RHEUMATISM	<input type="checkbox"/> YES <input type="checkbox"/> NO	HANDICAPS OR		STOMACH PROBLEMS	<input type="checkbox"/> YES <input type="checkbox"/> NO
ARTIFICIAL HEART VALVES	<input type="checkbox"/> YES <input type="checkbox"/> NO	DISABILITIES	<input type="checkbox"/> YES <input type="checkbox"/> NO	STROKE	<input type="checkbox"/> YES <input type="checkbox"/> NO
ARTIFICIAL JOINTS	<input type="checkbox"/> YES <input type="checkbox"/> NO	HEADACHES	<input type="checkbox"/> YES <input type="checkbox"/> NO	SWOLLEN FEET	
ASTHMA	<input type="checkbox"/> YES <input type="checkbox"/> NO	HEART MURMUR	<input type="checkbox"/> YES <input type="checkbox"/> NO	OR ANKLES	<input type="checkbox"/> YES <input type="checkbox"/> NO
BACK PROBLEMS	<input type="checkbox"/> YES <input type="checkbox"/> NO	HEART PROBLEMS	<input type="checkbox"/> YES <input type="checkbox"/> NO	SWOLLEN NECK GLANDS	<input type="checkbox"/> YES <input type="checkbox"/> NO
BLEEDING ABNORMALLY, WITH		HEPATITIS TYPE _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	THYROID PROBLEMS	<input type="checkbox"/> YES <input type="checkbox"/> NO
EXTRACTIONS OR SURGERY	<input type="checkbox"/> YES <input type="checkbox"/> NO	HERPES	<input type="checkbox"/> YES <input type="checkbox"/> NO	TONSILLITIS	<input type="checkbox"/> YES <input type="checkbox"/> NO
BLOOD DISEASE	<input type="checkbox"/> YES <input type="checkbox"/> NO	HIGH BLOOD PRESSURE	<input type="checkbox"/> YES <input type="checkbox"/> NO	TUBERCULOSIS	<input type="checkbox"/> YES <input type="checkbox"/> NO
CANCER	<input type="checkbox"/> YES <input type="checkbox"/> NO	JAUNDICE	<input type="checkbox"/> YES <input type="checkbox"/> NO	TUMOR/GROWTH ON HEAD	
CHEMICAL DEPENDENCY	<input type="checkbox"/> YES <input type="checkbox"/> NO	JAW PAIN	<input type="checkbox"/> YES <input type="checkbox"/> NO	OR NECK	<input type="checkbox"/> YES <input type="checkbox"/> NO
CHEMOTHERAPY	<input type="checkbox"/> YES <input type="checkbox"/> NO	KIDNEY DISEASE	<input type="checkbox"/> YES <input type="checkbox"/> NO	ULCER	<input type="checkbox"/> YES <input type="checkbox"/> NO
CIRCULATORY PROBLEM	<input type="checkbox"/> YES <input type="checkbox"/> NO	LIVER DISEASE	<input type="checkbox"/> YES <input type="checkbox"/> NO	VENEREAL DISEASE	<input type="checkbox"/> YES <input type="checkbox"/> NO
CONGENITAL HEART		LOW BLOOD PRESSURE	<input type="checkbox"/> YES <input type="checkbox"/> NO	WEIGHT LOSS,	
LESIONS	<input type="checkbox"/> YES <input type="checkbox"/> NO	MITRAL VALVE PROLAPSE	<input type="checkbox"/> YES <input type="checkbox"/> NO	UNEXPLAINED	<input type="checkbox"/> YES <input type="checkbox"/> NO
CONGENITAL HEART		NERVOUS PROBLEMS	<input type="checkbox"/> YES <input type="checkbox"/> NO	Do you wear contact lenses?	
DEFECT	<input type="checkbox"/> YES <input type="checkbox"/> NO	PACEMAKER	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
CONVULSIONS	<input type="checkbox"/> YES <input type="checkbox"/> NO	PSYCHIATRIC CARE	<input type="checkbox"/> YES <input type="checkbox"/> NO	Have you ever taken	
CORTISONE TREATMENTS	<input type="checkbox"/> YES <input type="checkbox"/> NO	RADIATION TREATMENT	<input type="checkbox"/> YES <input type="checkbox"/> NO	BISPHOSPHONATES	
COUGH, PERSISTENT		RESPIRATORY DISEASE	<input type="checkbox"/> YES <input type="checkbox"/> NO	or any Bone Building drug?	
OR BLOODY	<input type="checkbox"/> YES <input type="checkbox"/> NO	RHEUMATIC FEVER	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
DIABETES	<input type="checkbox"/> YES <input type="checkbox"/> NO	SCARLET FEVER	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, please list: _____	
EMPHYSEMA	<input type="checkbox"/> YES <input type="checkbox"/> NO	SHORTNESS OF BREATH	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	
EPILEPSY	<input type="checkbox"/> YES <input type="checkbox"/> NO	SINUS TROUBLE	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	
FAINTING OR DIZZINESS	<input type="checkbox"/> YES <input type="checkbox"/> NO	SKIN RASH	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	

WOMEN:

Are you pregnant? YES NO Due Date _____ Are you nursing? YES NO
 Taking birth control pills? YES NO

MEDICATIONS:

List any medications you are currently taking and the correlating diagnosis: _____

Pharmacy Name _____ Phone (_____) _____

ALLERGIES:

Aspirin Codeine Iodine Latex Local Anesthetic Sulfa
 Barbiturates (sleeping Pills) Penicillin Other _____

Authorization and Release. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to myself and or my child's health. It is my responsibility to inform the dental office of any changes in my or my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to myself or my child during the period of such care to third party payers and /or other health practitioners. I authorize and request my insurance company to pay directly to the Dentist or Dentist's group insurance benefits other wise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient or responsible party if a minor _____ Date _____

Signature of Dentist/Doctor's Review _____ Date _____