Welcome!

Verde Pointe Dental Associates
Drs Kimmerling McGrath & Fantaski

NEW PATIENT INFORMATION

Name_____ Preferred Name: _____Date of Birth: _____ ☐ Male ☐ Female

☐ Married ☐ Single ☐ Divorced ☐ Widowed Employer _____ ☐ College Student

Cell #_____ Work #_____ Email_____

Preferred Contact Method(s): ☐ Phone Calls ☐ Text Messages ☐ Emails ***Referred By?*** _____

Home #: _____ Home Address: _____

SSN: _____Emergency Contact_____ Phone #_____

DENTAL INSURANCE

Primary Dental Insurance Company_____Policy/Group#_____

Policy Holder's Name_____ Date of Birth _____SSN/ID#_____

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Dependent ☐ Domestic Partner

Secondary Dental Insurance Company_____Policy/Group#_____

Policy Holder' Name_____ Birth of Date _____ SSN/ID#_____

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Dependent ☐ Domestic Partner

DENTAL HISTORY

Reason for today's visit: _____ Year of Last Dental Visit: _____

YES	NO		YES	NO		YES	NO	
☐	☐	Hot/Cold Sensitivity	☐	☐	Grind/Clench Teeth	☐	☐	TMJ Pain/Jaw Popping
☐	☐	Past Periodontal Treatment	☐	☐	Sore/Bleeding Gums	☐	☐	Dry Mouth/Mouth Sores

Would you like to discuss? ***(Circle)*** Implants, Whitening, Crowns, Veneers, Bonding, Dentures, Straighter Teeth?

MEDICAL HISTORY

YES	NO		YES	NO		YES	NO	
☐	☐	Heart Problems	☐	☐	Kidney Disease	☐	☐	Use of Bisphosphonates
☐	☐	High Blood Pressure	☐	☐	Liver Disease	☐	☐	Pregnant (# of weeks ____)
☐	☐	Heart Valve Replacement	☐	☐	HIV / AIDS	☐	☐	Epilepsy / Seizures
☐	☐	Pacemaker	☐	☐	Hospitalized within last year	☐	☐	Hepatitis A B C (circle)
☐	☐	Diabetes (Type I or II)	☐	☐	Cancer or Chemotherapy	☐	☐	Bleeding Problems
☐	☐	Stroke	☐	☐	Joint Replacement (year ____)	☐	☐	Other (list below):

Other medical condition(s) _____

Any allergies? ☐ None ☐ Yes, please list: _____

Taking any medications? ☐ None ☐ Yes, please list: _____

_____

Print Name _____ Relationship _____

Signature _____ Date _____