VIBRANT SMILES
OF HOLLAND

New Patient Information Form

ABOUT YOU

Name: _____

I prefer to be called: _____

Home Address: _____

_____

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Birthdate: _____ **Age:** _____

Social Security #: _____

Email: _____

Home #: _____ **Cell #:** _____

Driver's License #: _____

Employer: _____

Employer Address: _____

_____ **Work #:** _____

Occupation: _____

Where and when is the best time to reach you?

_____

Whom may we thank for referring you?

_____

Previous/Present Dentist: _____

Last Visit Date: _____

SPOUSE INFORMATION

His/Her Name: _____

Employer: _____

Work #: _____ **SS#:** _____

Birthdate: _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____

Home #: _____ **Work #:** _____

Billing Address: _____

_____

Relation: _____ **SS#:** _____

Employer: _____

Birthdate: _____ **DL#:** _____

INSURANCE INFORMATION

Primary Coverage

Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone #: _____

Group #: _____

Insured's Name: _____

Insured's Birthdate: _____ **SS#:** _____

Insured's Employer: _____

Relationship: _____

Secondary Coverage

Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone #: _____

Group #: _____

Insured's Name: _____

Insured's Birthdate: _____ **SS#:** _____

Insured's Employer: _____

Relationship: _____

MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Office Phone #: _____

Last Visit Date: _____

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

_____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Please list any prescription/over-the-counter or herbal supplement drugs you are taking:

_____

_____

Have you ever taken Fosamax, or any other bisphosphonate or osteoporosis medication? ☐ Yes ☐ No

Do you have or have you ever had any of the following?

- ☐ Y ☐ N Abnormal Bleeding
- ☐ Y ☐ N Alcohol/Drug Abuse
- ☐ Y ☐ N Allergies
- ☐ Y ☐ N Anemia
- ☐ Y ☐ N Arthritis
- ☐ Y ☐ N Artificial Bones/Joints/Valves
- ☐ Y ☐ N Asthma
- ☐ Y ☐ N Blood Transfusion
- ☐ Y ☐ N Bypass Surgery
- ☐ Y ☐ N Cancer
- ☐ Y ☐ N Chemotherapy
- ☐ Y ☐ N Colitis
- ☐ Y ☐ N Congenital Heart Defect
- ☐ Y ☐ N Diabetes
- ☐ Y ☐ N Difficulty Breathing
- ☐ Y ☐ N Emphysema
- ☐ Y ☐ N Epilepsy
- ☐ Y ☐ N Fainting Spells
- ☐ Y ☐ N Fever Blisters
- ☐ Y ☐ N Frequent Headaches
- ☐ Y ☐ N Glaucoma
- ☐ Y ☐ N Hay Fever
- ☐ Y ☐ N Heart Attack
- ☐ Y ☐ N Heart Disease
- ☐ Y ☐ N Heart Murmur
- ☐ Y ☐ N Heart Surgery
- ☐ Y ☐ N Hemophilia
- ☐ Y ☐ N Hepatitis A
- ☐ Y ☐ N Hepatitis B
- ☐ Y ☐ N Hepatitis C
- ☐ Y ☐ N Herpes
- ☐ Y ☐ N High Blood Pressure
- ☐ Y ☐ N HIV / AIDS
- ☐ Y ☐ N HPV
- ☐ Y ☐ N Kidney Disease
- ☐ Y ☐ N Kidney Stones
- ☐ Y ☐ N Liver Disease
- ☐ Y ☐ N Low Blood Pressure
- ☐ Y ☐ N Mitral Valve Prolapse
- ☐ Y ☐ N Osteoporosis
- ☐ Y ☐ N Pacemaker/Defibulator
- ☐ Y ☐ N Psychiatric Problems
- ☐ Y ☐ N Radiation Therapy
- ☐ Y ☐ N Rheumatic Fever
- ☐ Y ☐ N Scarlet Fever
- ☐ Y ☐ N Seizures
- ☐ Y ☐ N Sexually Transmitted Disease
- ☐ Y ☐ N Shingles
- ☐ Y ☐ N Sickle Cell Disease/Traits
- ☐ Y ☐ N Sinus Problems
- ☐ Y ☐ N Stroke
- ☐ Y ☐ N Thyroid Problems
- ☐ Y ☐ N Tuberculosis (TB)
- ☐ Y ☐ N Ulcers

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

_____

_____

Are you allergic to any of the following?

- ☐ Y ☐ N Aspirin
- ☐ Y ☐ N Codeine
- ☐ Y ☐ N Dental Anesthetics
- ☐ Y ☐ N Jewelry
- ☐ Y ☐ N Latex
- ☐ Y ☐ N Metals
- ☐ Y ☐ N Antibiotics, list below:

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

_____

_____

_____

FOR WOMEN

Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No
If Yes, week #: _____

Are you nursing? ☐ Yes ☐ No

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

Do your gums ever bleed? ☐ Yes ☐ No

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

Do you now or have you ever experience(d) pain/discomfort in your jaw joint (TMJ)? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Would you like whiter teeth? ☐ Yes ☐ No

Fresher Breath? ☐ Yes ☐ No

How many times a week do you floss? _____

How many times a day do you brush? _____

Type of bristles? ☐ Soft ☐ Medium ☐ Hard

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

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 of 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** **Relationship to Patient** (if a Minor)

Anesthesia Consent

I, the undersigned patient, hereby give my consent for Dr. Jay Patel to administer an anesthetic prior to a dental procedure in order to achieve local anesthesia. I have agreed to the use of the anesthetic(s)** listed below to achieve the desired anesthetic affect.

I understand the risks inherent in anesthesia. I have discussed these risks with the dentist and acknowledge that they include, but are not limited to: allergic reaction, infection, bleeding, phlebitis (irritation of vein), nausea, blood clots, loss of limb function, paralysis, parasthesia, stroke, heart attack, brain damage, or death.

I give permission for the undersigned provider and any of his/her qualified associates to administer the anesthetic.

I have been given the opportunity to ask questions and express concerns I have about the anesthesia. The undersigned provider has answered my questions and addressed my concerns.

I confirm that I understand this form and the information contained therein. I am a native speaker of English or have been offered the services of a qualified translator who has explained the information in my native tongue.

** local anesthetics used by this office
4% Prilocaine plain
4% Articaine w 1:200000 epi
3% Mepivacaine plain
2% Mepivacaine w 1:20000 levonordefrin
2% Xylocaine w 1:100000 epi

Signature **Date** **Relationship to Patient** (if a Minor)

I have read the above and request that no local anesthesia be used during my treatment.

Signature **Date** **Relationship to Patient** (if a Minor)

OFFICE USE ONLY:
I verbally reviewed the medical/dental information above with the patient named herein. **Initials:** _____ **Date:** _____

Doctor's Comments: