New Patient Information

Patient Name:_____

How would you like to be addressed?_____

Mailing Address: _____

City:_____ State _____ Zip _____

Birthdate____/_____/_____ Age_____ Sex at birth **M F**

Marital Status: **Single** **Married** **Widow** **Separated** **Divorced**

Cell Phone _____ Email_____

Do you prefer text? **Y N** Best time to call: **Morning** **Mid-Day** **Afternoon/Evening**

Occupation _____ Employer _____

Time with employer _____ Work Phone _____

Work Address _____ City _____ State _____ Zip _____

Person to Contact in case of Emergency

Name_____ Phone _____ Relationship _____

Responsible Party Information (if different from patient)

Patient Name:_____

How would you like to be addressed?_____

Mailing Address: _____

City:_____ State _____ Zip _____

Birthdate____/_____/_____ Age_____ Sex at birth **M F**

Occupation _____ Employer _____

Time with employer _____ Work Phone _____

Work Address _____ City _____ State _____ Zip _____

Acknowledgement of Receipt of Notice of Privacy Policy

*You may refuse to sign this acknowledgement

I,_____, have received a copy of this office's Notice of Privacy Practices.

_____ _____ _____

Legal Name (Printed) Signature Date

Office Use Only: Reason for Refusal to Sign _____

Authorization to Release Information

I hereby authorize this facility to release my protected health information to:

_____ _____

Name Phone Number

_____ _____

Name Phone Number

_____ _____

Name Phone Number

Insurance Information

Medical Insurance: Primary Policy

Insurance Name _____

Address _____

Policy Holder Name _____ Relationship to Patient _____

Policy Holder Social Security Number ____ - ____ - ____ Member ID _____

Group Number _____ Policy Holder Date of Birth ___ / ___ / ____

Name of Employer _____ Employer Address _____

Medical History

Primary Care Doctor_____

Primary Care Office _____

Name of Specialty Doctor _____ Specialty _____

Have you been seen by your primary care physician in the last year? Yes No

Medication Drugs/ Allergies

Please circle any medication listed below that you are allergic to,or have had a bad reaction to:

Aspirin	Iodine	Vicodin	Hydrocodone	Oxycodone
Codeine	Tylenol	Ibuprofen	Tramadol	Penicillin
Amoxicillin	Erythromycin	Keflex	Z-Pack	Lidocaine
Tetracycline	Clindamycin	Sulfa	Nitrous Oxide	Latex

Please list any medications you are taking on a regular basis: _____

_____

Please list any medication you have taken in the last 6 months that you don't take on a regular basis: _____

Please circle the medical conditions that apply to you:

Hypertension	Aids	Hemophilia
Diabetes	Alcoholism	Hepatitis
Heart attack	anemia	HIV
Stroke	angina	Hives
Joint replacement	Asthma	Hyperactivity
Osteoporosis	Birth control	Hypoglycemia
Congenital heart defect	Low blood pressure	Jaundice
Blood thinners	Bruise easily	Kidney disease
Epilepsy / Seizures	Deaf	Liver disease
Drug dependency	Drug dependency	Mitral Valve Prolapse
Chronic pain therapy	Eating disorder	Night Sweats
Cancer	Emphysema	Paralysis
Chemotherapy	Fainting dizzy spells	Psychiatric treatment
Radiation therapy	Cold sores	Rheumatic fever
Obstructive sleep apnea	Gag easy	Sickle cell disease
CPAP machine	Glaucoma frequent	Sinus problems
Gerd/ acid reflux	Headaches	STDs
ADHD	Hives	Tuberculosis

Please list any other serious illness or medical conditions not listed above:

_____

Jaw and Airway Assessment

Clicking of the jaw joints	Yes	No
Pain in or around the ears	Yes	No
Difficulty opening or closing the mouth	Yes	No
Difficulty chewing	Yes	No
History of trauma to the jaw	Yes	No
Do you snore loudly	Yes	No
Do you grind or clench your teeth	Yes	No
Do you feel tired or fatigued during the day	Yes	No
Have you ever been diagnosed with TMJ/TMD	Yes	No
Have you ever had your airway measured	Yes	No