New Patient Information

Complete Dental Care
Comprehensive care that always puts patients first

Brent Ingram, DDS

Welcome to our practice.

Please take your time to fill out this form completely. The more we learn about you, the better care we are able to provide. We look forward to working with you to maintain a healthy, happy smile.

Patient Information

Patient Number _____

Today's date _____

First name _____ Middle initial _____ Last name _____

I prefer to be called (nickname, etc.) _____ ☐ Male ☐ Female

Address _____ City _____ State _____ ZIP _____

Date of birth _____ Social security no. _____

Home phone (___) ___-____ Work phone (___) ___-____ Cell phone (___) ___-____

Primary contact number (please check one) ☐ Home ☐ Work ☐ Cell Best time to call _____

E-mail _____

Fax (___) ___-____ Driver's license no. _____

Employer _____ Occupation _____

Spouse's name _____ Spouse's employer _____

Whom may we thank for referring you? _____

If the patient is a child

School _____ School phone (___) ___-____ Grade _____

Dental History

Reason for today's visit _____

Are you currently in pain? ☐ Yes ☐ No

If so, please describe: _____

Do you have any dental problems now? ☐ Yes ☐ No

If so, please describe: _____

Have you ever had trouble with a previous dental treatment? ☐ Yes ☐ No

If so, please describe: _____

Level of anxiety about seeing the dentist: (least) 1 2 3 4 5 (most)

Date of last dental exam _____ Date of last cleaning _____ Date of last full mouth X-rays _____

Procedure(s) done at last dental visit _____

Previous dentist's name _____

City _____ State _____ Phone (___) ___-____

Why are you changing dentists? _____

How often do you have dental examinations? _____ How often do you brush your teeth? _____

How often do you floss? _____ What type of bristles do you use? ☐ Hard ☐ Medium ☐ Soft

What other dental aids do you use? (Electric toothbrush, toothpick, etc.) _____

Do you require antibiotics before dental treatment?	☐ Yes	☐ No	Do you have frequent headaches?	☐ Yes	☐ No
Do your gums ever bleed?	☐ Yes	☐ No	Do you clench or grind your teeth?	☐ Yes	☐ No
Have you noticed any mouth odors or bad tastes?	☐ Yes	☐ No	Are your teeth sensitive to heat/cold?	☐ Yes	☐ No
Do you bite your lips or cheeks frequently?	☐ Yes	☐ No	Do you still have your wisdom teeth?	☐ Yes	☐ No

Complete Dental Care
Comprehensive care that always puts patients first

Brent Ingram, DDS

Have you ever had:

Periodontal disease/gum treatment	☐ Yes	☐ No	Discomfort in your jaw joint (TMJ/TMD)	☐ Yes	☐ No
Orthodontics treatment	☐ Yes	☐ No	Your teeth ground or bite adjusted	☐ Yes	☐ No
Oral surgery	☐ Yes	☐ No	Serious injury to the mouth or head	☐ Yes	☐ No
A bite plate or mouth guard	☐ Yes	☐ No			

If yes to any of the previous questions, please describe _____

Is there anything else about your past dental treatment(s) that you would like us to know? _____

Medical History

Have you been hospitalized or under the care of a medical doctor during the past 2 years? ☐ Yes ☐ No

If yes, for what? _____

Hospital or Physician's name _____ Phone _____

Hospital or Physician's City _____ State _____

Have you taken any medications or drugs in the past two years? ☐ Yes ☐ No

Are you currently taking any medications or drugs? (including regular doses of aspirin or over-the-counter medicines) ☐ Yes ☐ No

If yes, please explain _____

Do you have heart problems? ☐ Yes ☐ No

If so, what are the problems? _____

Do you use tobacco? ☐ Yes ☐ No

Women only:

Are you pregnant or think you may be pregnant?	☐ Yes	☐ No	Are you nursing?	☐ Yes	☐ No
Are you taking birth control pills?	☐ Yes	☐ No			

Indicate which of the following you have had or have at present:

AIDS/HIV	☐ Yes	☐ No	Difficulty Breathing	☐ Yes	☐ No	Lupus	☐ Yes	☐ No
Alcohol Addiction	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No
Drug Addiction	☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No	Nervousness/Anxiety	☐ Yes	☐ No
Allergies or Hives	☐ Yes	☐ No	Fainting or Dizzy Spells	☐ Yes	☐ No	Neurological Disorders	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Frequent Headaches	☐ Yes	☐ No	Psychiatric/		
Arthritis/Rheumatism	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Psychological Care	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	Hay Fever	☐ Yes	☐ No	Radiation Therapy	☐ Yes	☐ No
Joint Replacement	☐ Yes	☐ No	Heart (Surgery, Disease,			Rheumatic/Scarlet Fever	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Attack)	☐ Yes	☐ No	Shingles/Chicken Pox	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Heart Pacemaker	☐ Yes	☐ No	Sickle Cell Disease/Traits	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No	Hemophilia/Abnormal			Snoring/Sleep Apnea	☐ Yes	☐ No
Cancer/Chemotherapy	☐ Yes	☐ No	Bleeding	☐ Yes	☐ No	Stomach Problems/ Ulcers	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No	Hepatitis A B C (circle)	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Cold Sores/Herpes	☐ Yes	☐ No	High or Low Blood Pressure	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Colitis	☐ Yes	☐ No	Hospitalized for Any Reason	☐ Yes	☐ No	Tuberculosis (TB)	☐ Yes	☐ No
Cortisone Medicine	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Tumors	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Kidney Trouble	☐ Yes	☐ No	Venereal Disease/STD	☐ Yes	☐ No
Eating Disorder	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No			

Please list any serious medical condition(s) that you have ever had not listed above: _____

Are you aware of having an allergic (or adverse) reaction to any of the following:

Aspirin	☐ Yes	☐ No	Iodine	☐ Yes	☐ No	Sedatives	☐ Yes	☐ No
Codeine	☐ Yes	☐ No	Jewelry/Metals	☐ Yes	☐ No	Sulfa Drugs	☐ Yes	☐ No
Anesthetics (i.e. Novocaine)	☐ Yes	☐ No	Latex	☐ Yes	☐ No	Tetracycline	☐ Yes	☐ No
Erythromycin	☐ Yes	☐ No	Penicillin or Other Antibiotics	☐ Yes	☐ No	Other _____		

Patient signature _____

New Patient Information

Complete Dental Care
Comprehensive care that always puts patients first

Brent Ingram, DDS

Dental Insurance

Primary Carrier

Insurance co. name _____ Insurance co. phone _____

Address (Street, City, State, ZIP) _____

Group no. (Plan or Policy no.) _____ Insured's I.D. no. _____

Insured's name _____ Relationship to patient _____

Date of birth _____ Insured's social security no. _____

Insured's employer name _____ Is insured a patient in our practice? ☐ Yes ☐ No

Secondary Carrier

Insurance co. name _____ Insurance co. phone _____

Address (Street, City, State, ZIP) _____

Group no. (Plan or Policy no.) _____ Insured's I.D. no. _____

Insured's name _____ Relationship to patient _____

Date of birth _____ Insured's social security no. _____

Insured's employer name _____ Is insured a patient in our practice? ☐ Yes ☐ No

Person Financially Responsible for Account

Name _____ Relationship to patient _____

Social security no. _____ Phone (____) _____ - _____

Driver's license no. _____ Date of birth _____

Address (Street, City, State, ZIP) _____

Employer _____ Work phone (____) _____ - _____

Preferred payment method: ☐ Cash ☐ Credit Card ☐ Check

Visa/MC/AMEX no. _____ Exp. date _____

If patient is a minor, name of parent or legal guardian and relationship _____

Is this parent or legal guardian currently a patient in our office? ☐ Yes ☐ No

Payment is due in full at the time of treatment

(Unless prior arrangements have been approved)

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective healthcare provider or agency that may release such information to you. I will notify the dentist of any changes in my health or medication.

Signature _____ *Date* _____

Person to contact in case of emergency

Name _____ Relationship _____

City _____ State _____ Cell phone _____

Home phone _____ Work phone _____

OFFICE USE ONLY

I VERBALLY REVIEWED THE MEDICAL / DENTAL INFORMATION ABOVE WITH THE PATIENT NAMED HEREIN.

Date _____ Initials _____

Smile Analysis

Complete Dental Care
Comprehensive care that always puts patients first

Brent Ingram, DDS

Today's date _____ **Patient Number** _____

1. Do you love the way your smile looks? ☐ Yes ☐ No

2. Do you feel comfortable showing your teeth when you laugh or smile? ☐ Yes ☐ No

3. If you could change anything about your smile, it would be (check all that apply):

☐ Color of your teeth ☐ Too much or too little of teeth show when you smile ☐ Gaps between your teeth
☐ Size/Shape of your teeth ☐ Too much or too little of gum shows when you smile ☐ Alignment of your teeth
☐ Other: _____

4. Do you have (check all that apply):

☐ Sensitive or receding gums ☐ Worn/broken/chipped teeth ☐ Old or discolored fillings ☐ Missing teeth
☐ Old crowns that have dark edges at the top ☐ Other: _____

5. In your line of work or lifestyle, do you (check all that apply):

☐ Visit businesses or clients ☐ Travel ☐ Speak publicly ☐ Other: _____

6. If you had a smile makeover do you think you'd feel (check all that apply):

☐ More confident ☐ More optimistic ☐ Healthier
☐ Just OK ☐ No different ☐ Other: _____

7. Do you or someone in your family have issues with any of the following (check all that apply):

☐ Chronic bad breath ☐ Grinding teeth ☐ Snoring
☐ Other: _____

We'd like to know more about you so we can better serve you!

8. Do you prefer appointments in the (check all that apply):

☐ Early morning ☐ Early afternoon ☐ No preference
☐ Late morning ☐ Late afternoon ☐ Other: _____

9. What are your favorite hobbies or activities?

_____
_____
_____

10. Do you have children and grandchildren? If so, please list their names and ages.

_____
_____
_____

11. Is there anything else that you want our office to know about you that will help us to serve you better?

_____
_____
_____