****

**NEW PATIENT INFORMATION**

Welcome to Summit Dental Clinic! Thank you for choosing us as your dental healthcare team. In order for us to meet your needs, please fill out this form completely. If you have any questions, do not hesitate to ask us- we are happy to help!

GENERAL INFORMATION

 DATE:

FULL NAME:

DATE OF BIRTH:

SEX: M F

OCCUPATION:

EMAIL ADDRESS:

HOME ADDRESS:

MOBILE/CELL NUMBER:

EMERGENCY CONTACT- NAME:

 CONTACT NUMBER:

 RELATIONSHIP TO PATIENT:

ARE THERE ANY MEMBERS OF YOUR FAMILY SEEN IN OUR OFFICE? If yes, please list:

HOW DID YOU HEAR ABOUT US? (please check all that apply):

Google Instagram/Facebook family/friend Practo/online other

I AM INTERESTED IN LEARNING MORE ABOUT THE FOLLOWING DENTAL SERVICES- (please check all that apply):

Cosmetic fillings root canal treatment whitening/ bleaching orthodontic treatment/braces

Implant crowns & bridges Invisalign teeth cleaning dentures joint pain

Gum treatment tooth removal ceramic veneers

DENTAL HISTORY

WHY DID YOU CHOOSE TO VISIT OUR OFFICE TODAY? ( please check all that apply)

Dental pain second opinion interested in a particular service other

WHEN WAS YOUR LAST DENTAL VISIT?

DO YOUR GUMS BLEED WHEN YOU BRUSH/ FLOSS? Yes No

DO YOU CLENCH/ GRIND YOUR TEETH? Yes No

MEDICAL HISTORY

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICAN? If yes, please explain:

ARE YOU TAKING ANY PRESCRIPTION/ OVER THE COUNTER MEDICATION? If yes, please list:

FOR WOMEN- ARE YOU PREGNANT? Yes (if yes; mention week) No

HAVE YOU HAD/ HAVE THE FOLLOWING MEDICAL ISSUES? ( check all that apply)

* Abnormal bleeding
* Anemia
* Angina pectoris
* Arthritis
* Artificial bones/ joints
* Heart surgery
* Hepatitis
* High BP
* HIV+/ AIDS
* Kidney problems
* Liver disease
* Asthma
* Blood transfusion
* Cancer/ chemotherapy
* Congenital heart defect
* Diabetes
* Drug abuse
* Emphysema
* Epilepsy/seizures
* Fainting spells
* Frequent headaches/ migraine
* Glaucoma
* Heart attack
* Hemophilia
* Low BP
* Nervous/anxious
* Pacemaker
* Psychiatric issues
* Radiation treatment
* Shingles
* Sinus problems
* Stroke
* Thyroid problems
* Others

ARE YOU ALLERGIC TO THE FOLLOWING?

* Aspirin
* Dental anesthetics
* Latex
* Penicillin
* Erythromycin
* Sulfur drugs
* Others

I, the undersigned, certify that I have read and understood the above information to the best of my knowledge. The above questions have been accurately answered and I understand that providing incorrect information can be detrimental to my dental treatment and overall health. I agree to be responsible for the payment off all services rendered on my behalf or my dependents. I hereby give my consent to Summit Dental Clinic to perform the necessary treatment procedures as they deem necessary. I have been informed that there are inherent risks involved in the treatment / procedure. I have signed this consent voluntarily out of my free will without any pressure and in my full senses.

SIGNATURE OF PATIENT/ PARENT/ GUARDIAN DATE