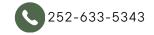


## Welcome! NEW PATIENT FORM

Date : \_\_\_\_\_

PATIENT INFORMATION	
First Name:	Last Name:
Birth Date:	Gender: Male Female
	Preferred Pronouns:
Address:	
	e: ZIP
Email:	
Marital Status: Married Single	
Emergency Contact:	Phone:
Relationship to patient:	
Patient Employer/School:	
How did you hear about us?	
○ I live/work in area ○ I was referred by	
O Social media O Google	
Other	
INSURANCE INFORMATION	
○ No Dental Insurance    ○ Primary Insurance	
Who is responsible for this account?	
Relationship to Insurance holder: Self	
Name of Insurance Company:	State:
Policy Holder Name:	
Policy Holder SS#:	
Member ID:	
Name of Employer:	
Is the patient covered by additional insurance?	) Yes () No
Name of Insurance Company:	Group #:
INSURANCE ASSIGNMENT AND RELEASE	
	coverage with and assign directly
to Dr. <u>Victoria McGowen</u> all insurance benefits, if any, or am financially responsible for all charges whether or no insurance submissions. The above-named dentist may o	coverage with and assign directly (Name of Insurance company)  therwise payable to me for any services rendered. I understand that I t paid by insurance. I authorize the use of my signature on all use my health care information and may disclose such information to ents for the purpose of obtaining payment for services and for related services.
 Patient Signature	 Date





DENTAL HISTORY									
Previous Dentist:				Office Name:					
City/State:			Da	Date of last dental visit:					
Date of last dental vis	sit:								
CHECK "YES" OR	"NO" IF	YOU	HAVE HAD ANY	OF THE F	OLLOW	ING:			
		Yes:	No:			Yes: No:			
Bad breath		0	C Loose te						
Bleeding or sore gum	IS	0	O Ser	nsitvity to h	not or col	d () ()			
Ulcers on lip or tongu	ie	$\circ$	O Ser	nsitvity to s	sweets	0 0			
Burning sensation on	tongue	$\circ$	O Ser	nsitvity whe	en biting	0 0			
History of smoking or	vaping	$\circ$	O Gri	nding or cl	enching	0 0			
Clicking or popping of	of jaw	$\circ$	O Jav	v pain or te	enderness				
Any bad reactions to	dental a	nesthe	sia in the past?	Yes 🔘	No				
How anxious are you	for denta	al treat	ment? O None	○ Sligh	ntly ()	Very C Extremely			
MEDICAL HISTOR	Υ								
Physician's Name:									
Have you ever taken Boniva. Yes	-	oonate	medication? Comn	non brand	names ar	re Fosamax, Actonel, At	elvia, Di	dronel,	
CHECK "YES" OR	"NO" IF	YOU	HAVE HAD ANY	OF THE F	OLLOW	ING:			
	Yes:	No:	B	Yes:	No:		Yes:	No:	
High blood pressure	0	0	Diabetes	0	0	Arthritis, Rheumatisr	n O	0	
Anemia	0	0	Thyroid Problems	_	0	Artificial joints	0	0	
Heart Murmur	0	0	Acid Reflux	0	0	Back, Neck problem	-	0	
Heart Problems	0	0	Kidney Disease	0	O	Cortisone treatment	s ()	0	
Bleeding Disorders	0	0	Cirrhosis of liver	0	0	Epilepsy	0	0	
Pacemaker	0	0	Asthma	0	0	Fainting or dizziness	$\sim$	0	
Artificial Heart Valves	0	0	Emphysema	0	0	POTS	$\circ$	0	
Congestive Heart Failure	$\circ$	$\circ$	Tuberculosis	0	0	History of cancer:	O	O	
AIDS/HIV	$\bigcirc$	0	Herpes	0	0	If yes, what type:_			
History of heart attac	k ()	$\bigcirc$	Hepatitis	0	0	Radiation treatment	0	0	
•	_	ccurre	nce:			Pregnant	0	0	
History of stroke	$\bigcirc$	$\bigcirc$				Currently nursing	O	O	
If yes, when was	the last c	occurre	ence:						
MEDICATIONS/AL	LERGIE	S							
List any medications	you are o	current	ly taking:						
CHECK IF YOU AR	E	DCIO	TO ANY OF THE	EOLL 034	INC:				
Local anesthetic									
C) Local allestriction	U Pen	IICIIIIN	Sulla drugs (	, aspirin (	ر omer				