PRAIRIE ROOTS DENTAL STUDIO

# New Patient Form

**Insurance Information:**

**Primary Insurance Provider If Applicable:**

Name of Insurance Plan or Government Program: ______________________________________________

Full Name of the Policy Holder as it Appears on Insurance Documents: ______________________________

Is the Policy Holder a Patient in Our Office? Yes: ☐ No: ☐ Relationship to Policy Holder: _____________

Policy Holders Date of Birth: _________________

Policy/Certificate ID #: ___________________________ Group/Plan #: _____________________________

Treaty Number/Health Card Number if Government Insurance: _____________________________________

If Known, Annual Deductible: _________________ Yearly Limit: _____________% of Coverage: ________

**Secondary Insurance Provider If Applicable:**

Name of Insurance Plan or Government Program: ______________________________________________

Full Name of the Policy Holder as it Appears on Insurance Documents: ______________________________

Is the Policy Holder a Patient in Our Office? Yes: ☐ No: ☐ Relationship to Policy Holder: _____________

Policy Holders Date of Birth: _________________

Policy/Certificate ID #: ___________________________ Group/Plan #: _____________________________

Treaty Number/Health Card Number if Government Insurance: _____________________________________

If Known, Annual Deductible: _________________ Yearly Limit: _____________% of Coverage: ________

**Preferred Method of Billing Insurance:**

☐ I would like to pay at the time of my treatment and have my insurance company reimburse me directly (non-assignment).

☐ I would like the insurance company to pay the dentist directly (assignment). I understand that I am responsible for any and all amounts not covered by my insurance plan, no matter the reason.

**Referral Information**

Whom may we thank for referring you to our practice?

☐ Another Patient, Friend ________________________________

☐ Another Patient, Relative ________________________________

☐ Dental Office ________________________________________

☐ Phone Book ☐ Outdoor Sign ☐ Website/Google ☐ Facebook

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# New Patient Form

## Dental History

Name of Previous Dentist or Office: ______________________________

Phone Number: ______________________ Fax Number: ______________________

Date of Last Dental Visit: __________________ Reason for Visit: ______________________

Why are you changing dentists? ______________________________

Is this office visit for emergency dental care? Yes: ☐ No: ☐

If yes, please explain why: ______________________________

What would you like to accomplish at this appointment? ______________________________

Do you have pain or discomfort in your mouth? Yes: ☐ No: ☐

If Yes: Do you have pain when eating? Yes: ☐ No: ☐

Do you have pain during the day? Yes: ☐ No: ☐

Do you have pain that wakes you up in the night? Yes: ☐ No: ☐

Do you have sensitivity to hot and cold? Yes: ☐ No: ☐

Have you ever had an adverse reaction to local anesthetic? Yes: ☐ No: ☐

If yes, Please explain: ______________________________

Have you ever had any serious trouble associated with any previous dental treatment? Yes: ☐ No: ☐

If yes, Please explain: ______________________________

How long since your last dental X-rays? ☐ Weeks ☐ Months ☐ Years

Does dental treatment make you nervous? ☐ Not at all ☐ Slightly ☐ Moderately ☐ Extremely

Are you currently under active dental treatment? Yes: ☐ No: ☐

If so, Where? ______________________________

What? ______________________________

Have you ever had bleeding or swollen gums? Yes: ☐ No: ☐

If so, When? ______________________________

Have you ever experienced dry mouth? Yes: ☐ No: ☐

If so, When? ______________________ For how long? ______________________

Have you ever been told that you have gum disease? Yes: ☐ No: ☐

If so, what treatment was done? ______________________________

How often do you usually get your teeth professionally cleaned? ______________________________

When was your last cleaning? ______________________________

Have you ever had any of the following? (check all that apply)

- ☐ Tooth Extractions
- ☐ Dental/Oral Surgery
- ☐ Root Canal Therapy
- ☐ Removable Partial Denture
- ☐ Fixed Bridge
- ☐ Complete Denture
- ☐ Filling
- ☐ Crown
- ☐ Inlay/Onlay
- ☐ Dental Implant
- ☐ Orthodontic Treatment (braces, Invisalign)

With respect to your jaw joints, do you have any of the following?

☐ Clicking, popping or grinding noises ☐ Pain on opening ☐ Locking

Do you have any concerns with your mouth? Yes: ☐ No: ☐

If yes, Please explain: ______________________________

Are you happy with the appearance of your smile? Yes: ☐ No: ☐

If no, Please explain: ______________________________

Are you nervous during dental treatment? Yes: ☐ No: ☐

To the best of my knowledge, all of the preceding answers and information provided are true and correct.

Signature: ______________________________ Date: ______________________