New Patient Form

Burns Dental Care

Name: Last First Middle

Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Address:	City:	State:	Zip:
Email:	Home Phone: *Include area code* ( )	Cell Phone: *Include area code* ( )	
Date of Birth:	SS#:	Sex: M F	
Emergency Contact:	Relationship:	Home Phone: *Include area code* ( )	Cell Phone: *Include area code* ( )

If you are completing this form for another person, what is your relationship to
Your Name: *Relationship:*

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the question.)*

	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information

Please answer the following questions:	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Do you clench or grind your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you ever had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

Date of your last dental exam: _____

Date of your last dental cleaning: _____

Date of your last dental x-rays: _____

What is the reason for your dental visit today?

_____

_____

Medical Information

Please answer the following questions: *(Check DK if you Don't Know the answer to the question.)*

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐
Do you currently take any medications? (This includes over the counter, vitamin, herbal remedy, etc.)	☐	☐	☐

Primary Care Physician Name: _____

Phone: _____

Address/State/City/Zip: _____

If yes, what was the illness or problem? _____

If yes, please provide the names of the medications:

_____ _____

_____ _____

_____ _____