Rochester Hills Dental
Quality. Comfort. Trust.

NEW PATIENT FORM

1 PATIENT INFORMATION

Name: _____ ☐ Male ☐ Female | ☐ Married ☐ Single ☐ Divorced ☐ Minor ☐ Partnered ☐ Widowed

I prefer to be called: _____

Date of Birth: ___/___/_____ Age: _____ S.S. #: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____ ext. _____

E-mail Address: _____ Employer: _____

Responsible Party (if different from above): _____ Relation: _____

Date of Birth: ___/___/_____ S.S. #: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____ ext. _____

E-mail Address: _____ Employer: _____

2 INSURANCE INFORMATION

Insurance Company Name: _____ Phone: (____) _____

Group / Policy #: _____ ID # (as shown on card): _____

Insured's Name: _____ Relation: _____ Insured's Date of Birth: ___/___/_____

Insured's S.S. #: _____ Insured's Employer: _____

Additional Insurance Information (secondary if applicable)

Insurance Company Name: _____ Phone: (____) _____

Group / Policy #: _____ ID # (as shown on card): _____

Insured's Name: _____ Relation: _____ Insured's Date of Birth: ___/___/_____

Insured's S.S. #: _____ Insured's Employer: _____

3 DENTAL HISTORY

Reason for Visit: _____ Date of Last Visit: _____

Do you currently, or have you ever experience(d) any of the below issues? Please check all that apply.

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Clicking or Popping of Jaw
- ☐ Food Collection Between Teeth
- ☐ Grinding Teeth
- ☐ Loose Teeth or Broken Fillings
- ☐ Periodontal Treatment
- ☐ Sensitivity to Cold
- ☐ Sensitivity to Hot
- ☐ Sensitivity to Sweets
- ☐ Sensitivity when Biting
- ☐ Sores or Growths in your Mouth

4 MEDICAL HISTORY

Physician's Name: _____ Date of Last Visit: _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of lominim, Adipex, Fastin (brand names of phentermine, Pondimin (fenfluramine and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you ever used Bisphosphonates or Osteoperosis medication? ☐ Yes ☐ No

Have you ever had any serious illnesses or operations? ☐ Yes ☐ No Describe: _____

Have you ever had a blood transfusion? ☐ Yes ☐ No Date: _____

(Women)

Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control? ☐ Yes ☐ No

Do you currently have, or have you ever had any of the following? Please check all that apply.

- ☐ Anemia
- ☐ Arthritus / Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints, Pins, etc.
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Abnormally
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatments
- ☐ Cough, Persistant
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitus: Type: _____
- ☐ Hernia Repair
- ☐ High Blood Pressure
- ☐ HIV / AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolepses
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Snoring
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems: _____
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

List current medications and correlating diagnosis: _____

_____

Allergies: _____

5 AUTHORIZATION AND RELEASE

The above information is complete and accurate to the best of my knowledge. I understand it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I assign directly to Rochester Hills Dental all insurance benefits, if any otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. Ohlsson may use my health care information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services.

_____ _____

Signature of Patient, Guardian or Personal Representative Date