nurture
FAMILY DENTAL

WELCOME TO OUR NEST!

NEW PATIENT FORM

PERSONAL INFORMATION

First Name/Last Name :

PREFERRED NAME :

Date Of Birth : ____ / ____ / ____ **Gender** : ☐ Male ☐ Female

Address : ____

Phone Number : ____ **E-Mail** : ____

Parent/Guardian Name (Under 18) : ____ **Social Security #** : ____

Status : ☐ Single ☐ Married ☐ Divorce ☐ Others

Occupation : ____

For your convenience, we offer the following method of payments. Which will you be using for co-payments?

☐ **Cash** ☐ **Check** ☐ **Credit Card** ☐ **Google/Apple Pay** ☐ **Other**

Emergency Contact Name : ____ **Emergency Contact Phone** : ____

INSURANCE POLICY DETAILS

Policy Holder Name : ____ **Dental Insurance Company** : ____

Relationship to policy holder : ____ **Employer Name** : ____

ID Number : ____ **Group #** : ____

SO GLAD YOU ARE HERE! HOW DID YOU HEAR ABOUT US?

☐ **Website** ☐ **Newsletter**

☐ **Google** ☐ **Social Media**

☐ **Radio** ☐ ____

Our Favorite...A *PERSONAL REFERRAL!*
Please let us know who we can thank for referring you and your family to us. We LOVE giving back to our patients!

Referral Name

____

Doctor Signature ____ **Patient Signature**

Date ____ **Date**

More Information :

6259 Grand River Rd. Brighton,MI 48114

810.227.2744 (Office)

www.nurturefamilydental.com

THANK YOU

nurture FAMILY DENTAL

MEDICAL HISTORY

Physician Name : _____

Office Phone : _____

Are you under Medical treatment now? Yes ☐ No ☐

Are you taking any medication(s) including non-perscription? Yes ☐ No ☐

If yes, what medication?

_____

_____

Have you been hospitalized for any surgical operation or serious illness within the last 5 years? Yes ☐ No ☐

If yes, please explain : _____

	Yes	No
Have you taken Viagra, Revatio, Cialis, or Levitra in the last 24 hours?	☐	☐
Do you use tobacco?	☐	☐
Do you use controlled substances?	☐	☐
Woman Only:		
Are you Pregnant or think you may be?	☐	☐
Are you Nursing?	☐	☐
Are you taking oral contraceptives?	☐	☐

	Yes	No
Have you ever taken Fen-Phen/Redux?	☐	☐
Have you ever taken Fosamax, Boniva, Actonel, or any cancer medication containing bisphophonates?	☐	☐

What pharmacy do you use?

_____

DO YOU HAVE ANY OF THE FOLLOWING?

	Yes	No
High Blood Pressure	☐	☐
Heart Attack	☐	☐
Rheumatic Fever	☐	☐
Swollen Ankles	☐	☐
Fainting/Seizures	☐	☐
Asthma	☐	☐
Low Blood Pressure	☐	☐
Epilepsy/Convulsion	☐	☐
Leukemia	☐	☐
Diabetes	☐	☐
Kidney Disease	☐	☐
AIDS or HIV	☐	☐
Thyroid Problem	☐	☐

	Yes	No
Heart Disease	☐	☐
Cardiac Pacemaker	☐	☐
Heart Murmur	☐	☐
Angina	☐	☐
Frequently Tired	☐	☐
Anemia	☐	☐
Emphysema	☐	☐
Cancer	☐	☐
Arthritis	☐	☐
Joint Replacement	☐	☐
Hepatitis/Jaundice	☐	☐
Ulcers	☐	☐
Chest Pains	☐	☐

	Yes	No
Easily Winded	☐	☐
Stroke	☐	☐
Hay Fever/Allergies	☐	☐
Tuberculosis	☐	☐
Radiation Therapy	☐	☐
Glaucoma	☐	☐
Recent Weight Loss	☐	☐
Liver Disease	☐	☐
Heart Trouble	☐	☐
Respiratory Problem	☐	☐
Mitral Valve Prolapse	☐	☐

Other : _____

PATIENT DENTAL HISTORY

Name of Previous dentist and location? _____ **Date of last exam** _____

	Yes	No
Do your gums bleed while brushing/flossing?	☐	☐
Are your teeth sensitive to hot or cold liquids?	☐	☐
Are your teeth sensitive to sweet or sour foods?	☐	☐
Do you feel pain to any of your teeth?	☐	☐
Do you have any sores/lumps in or near your mouth?	☐	☐
Have you had any head, neck or jaw injuries?	☐	☐
Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
Do you have frequent headaches?	☐	☐
Do you clench or grind your teeth?	☐	☐
Do you bite your lips or cheeks?	☐	☐
Have you ever had any difficult extractions in the past?	☐	☐
Have you had any orthodontic treatment?	☐	☐
Do you wear dentures or partials?	☐	☐
If yes, date of placement _____		
Have you ever received oral hygiene instructions regarding care for your teeth?	☐	☐
Do you like your smile?	☐	☐

ALLERGIES:

	Yes	No
Local Anesthetics	☐	☐
Penicillin	☐	☐
Sulfa Drugs	☐	☐
Sedatives	☐	☐
Latex	☐	☐
Other	☐	☐

_____

I certify that I have read and understand the above information to the best of my knowledge. The questions above have been answered accurately. I understand that providing incorrect information can be dangerous to my health.

_____

Patient Name