New Patient Form

Name　　　　　　　　　　　　　　　　　　　　Date　　/　　/

Gender　Male / Female　　Date of Birth　　/　　/　　Age　　Nationality

Address 〒

Phone Home　　　　　　Mobile　　　　　　Mail address

Company Name　　　　　　　　　　　　　　Phone

Name of person referring you to our practice

Insurance coverage　Yes / No　INSURANCE COMPANY NAME

■What is your immediate dental concern?

☐sore teeth ☐caries ☐filling came out ☐bleeding/swollen gums ☐floating teeth ☐want a denture
☐want to clean my teeth ☐whitening ☐teeth are uneven ☐check up ☐interested in Implant
☐jaw problems(TMJ) ☐clench/grind teeth ☐dry mouth ☐others(　　　　　　　　)

■Most recent dental exam/treatment (　　　　　)

Have you ever had any promblems with effectiveness or bad reactions to dental anesthetic?
☐YES (　　　　　　　　　　　　　　　　　　　　)☐NO

■Have you ever had the following :

☐hospitalization for illness or injury (　　　　　　　　　　　　)
☐heart problems ☐high blood pressure ☐a stroke ☐tuberculosis ☐athma ☐sinus problems
☐kidney disease ☐liver disease ☐diabetes ☐digestive disorder ☐epilepsy/convulsions/seizures
☐hepatitis(type　　) ☐HIV/AIDS ☐psychiatric treatment

■Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment

■List any medications, supplements or vitamins taken within the last two years

■Have you ever had allergic reaction to

☐aspirin, ibuprofen, acetomenophen ☐penicillin ☐tetracycline ☐local anesthetic
☐metals(gold, stainless steel) ☐ohers(　　　　　　) ☐foods(　　　　　　　)
FEMALE － ☐pregnant(　　month) ☐taking birth control pills

■Name of office or other source referring you to our practice　(ex.)internet homepages

■Do you smoke? ☐YES- How many ?　　　/day How long ?　　　　years ☐NO

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY
OR ANY MEDICATIONS YOU MAY BE TAIKING.

Patient's Signature　　　　　　　　　　　　　　　　Date

Doctor's Remarks

Doctor's Signature