New Patient Form:

TOOMEYDENTISTRY

Name: _____ Date: _____

Address: _____ DOB: _____

_____ MARITAL STATUS: (circle)

S M D W

Email Address: _____

Cell: _____ Work: _____ Home: _____

(Please circle the best number to reach you.)

EMERGENCY CONTACT & PHONE: _____

How did you hear about us? _____

Are you happy with your smile? YES If NO, Why? _____

Has your physician told you to pre-medicate w/antibiotics, prior to dental work? Yes No

Are you taking biophosphate drugs? (ie: Fosamax, Actonel, Boniva) Yes No

Are you on a daily regimen of aspirin? Yes No

Are you taking Coumadin or other blood thinners? Yes No

If yes, how many days prior to dental appointments, did your Dr tell you to stop it? _____

Have you had any surgeries *in the last year*? Yes No

If yes, list surgery and approximate date: _____

Do you currently have, or had in the past: (*Circle Yes or No for each.*)

Acid Reflux	Y N	Gag Easily	Y N	Mouth Swelling	Y N
Bad Breath	Y N	Grind Your Teeth	Y N	Orthodontic Work	Y N
Bleeding Gums	Y N	Gum Surgery	Y N	Pain with Cold	Y N
Drug Use	Y N	Headaches Often	Y N	Pain with Hot	Y N
Eating Disorder	Y N	Jaw pops/clicks	Y N	Smoke/Chew	Y N
Fainting Spells	Y N	Mouth Blisters	Y N	Tired/sore Jaws	Y N

Do you currently have, or had in the past: (*Please describe where needed.*)

Anemia	Y N	Heart Murmur	Y N	Lupus	Y N
Arthritis	Y N	High Blood Pressure	Y N	Mitrovalve Prolapse	Y N
Asthma	Y N	HIV+	Y N	Psychiatric Care	Y N
Cancer	Y N	Joint Replacement	Y N	Rheumatic Fever	Y N
Diabetes	Y N	Kidney Disease	Y N	Stroke	Y N
Epilepsy	Y N	Liver Problems	Y N	Tuberculosis	Y N
Hepatitis	Y N	Low Blood Pressure	Y N	Ulcers	Y N

Do you have any conditions NOT listed above? _____

Drug Allergies: _____

Food/Latex Allergies: _____

Women: Are you pregnant? Y N **Approx. Date of Last Menstrual Cycle:** _____/_____/_____

List all medications you currently take (*prescription AND over-the-counter*):

Medication:	Strength/mg	Frequency per day
Medicaton:	Strength/mg	Frequency per day
Medication:	Strength/mg	Frequency per day
Medication:	Strength/mg	Frequency per day
Medication:	Strength/mg	Frequency per day
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Primary Care Physician: _____ Phone: _____

Signature of Patient (or Guardian): _____

Printed Name: _____