Sophia Nichols, DMD, MAGD, PA
General & Cosmetic Dentistry

Welcome Patient Form

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain optimal oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

ABOUT YOU

Today's Date:

Email:

Name: Last First Initial

I prefer to be called:

Date of Birth:

SS#: Age:

Home Address:

Apt/Condo# City State Zip Code

Home Phone:

Work Phone: Direct Line /Ext. :

Cell Phone:

Employer:

Employer Address:

City State Zip Code

How long there?: Occupation:

Where and when are the best times to reach you?:

Whom may we Thank for referring you?:

Other family members seen by us:

Previous Dentist:

Person Responsible for Account:

SPOUSE INFORMATION

His/Her Name: Last First Initial

Employer:

Contact Phone #: Direct Line /Ext. :

SS#:

Date of Birth:

Driver License #:

Relative or Friend not living with you (for emergency).

His/Her Name:

Contact Phone #:

Payment is due in full at time of treatment.
Unless prior arrangements have been approved

INSURANCE

PRIMARY INSURANCE

Dental Coverage: YES NO

Insurance Co. Name:

Insurance Company Address:

City State Zip Code

Insurance Company Phone#:

Group # (Plan, Local or Policy #):

Insured's Name:

Relationship:

Insured's Birthdate: Insured's ID#:

Insured's Employer:

Employer's Address:

City State Zip Code

SECONDARY INSURANCE

Dental Coverage: YES NO

Insurance Co. Name:

Insurance Company Address:

City State Zip Code

Insurance Company Phone#:

Group # (Plan, Local or Policy #):

Insured's Name:

Relationship:

Insured's Birthdate: Insured's ID#:

Insured's Employer:

Employer's Address:

City State Zip Code

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all cost of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my company.

Signature Date
(please print out and sign)

MEDICAL HISTORY (732) 458-5400

Do you have a personal physician? YES NO

Physician's Name?

Phone Number: Date of last visit:

Your current physical health is: GOOD FAIR POOR

Are you currently under a physician's care? YES NO

Please explain:

Do you smoke or use tobacco in any form? YES NO

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? YES NO

Are you taking any prescriptions or over the counter drugs? YES NO

If YES, Please list:

Have you taken Fosamax, or any other bisphosphonate?: YES NO

For Women:

Are you using a prescribed method of birth control? YES NO

Are you pregnant?: YES NO Week #:

Are you nursing?: YES NO

Have you ever had any of the following diseases or medical problems?:

YES NO Abnormal Bleeding/Hemophilia
YES NO AIDS
YES NO Alcohol / Drug Abuse
YES NO Anemia
YES NO Arthritis
YES NO Artificial Bones/Joints/Valves
YES NO Asthma
YES NO Blood Transfusion
YES NO Cancer/Chemotherapy
YES NO Colitis
YES NO Congenital Heart Defect
YES NO Diabetes
YES NO Difficulty Breathing
YES NO Emphysema
YES NO Epilepsy
YES NO Fainting Spells
YES NO Frequent Headaches
YES NO Glaucoma
YES NO Hay Fever
YES NO Heart Attack / Surgery
YES NO Heart Murmur
YES NO Hepatitis
YES NO Herpes/Fever Blisters
YES NO High Blood Pressure
YES NO HIV
YES NO Hospitalized for any Reason
YES NO Kidney Problems
YES NO Liver Disease
YES NO Low Blood Pressure
YES NO Lupus
YES NO Mitral Valve Prolapse
YES NO Pacemaker
YES NO Psychiatric Treatment
YES NO Radiation Treatment
YES NO Rheumatic / Scarlet Fever
YES NO Seizures
YES NO Shingles
YES NO Sickle Cell Disease/Traits
YES NO Sinus Problems
YES NO Stroke
YES NO Thyroid Problems
YES NO Tuberculosis (TB)
YES NO Ulcers
YES NO Venereal Diseases

Please list any serious medical conditions(s) that you have had:

Are you allergic to any of the following:

YES NO Aspirin
YES NO Codeine
YES NO Dental Anesthetics
YES NO Erythromycin
YES NO Jewelry/Metals
YES NO Latex
YES NO Penicillin
YES NO Tetracycline
YES NO Other

Please list any other drug/materials that you are allergic to:

OFFICE USE ONLY / MEDICAL HISTORY UPDATE

Has there been any change in your health status since your last visit?
If YES, please explain:

Has there been any change in your health status since your last visit?
If YES, please explain:

DENTAL HISTORY

Why have you come to the dentist today?

Do you require antibiotics before dental treatment? YES NO
If Yes, why?

Are you currently in pain? YES NO

Your current dental health is: GOOD FAIR POOR

Have you ever had a serious/difficult problem associated with any previous dental work? YES NO

Do you floss daily? YES NO

Brush daily?

Type of bristles on your toothbrush? HARD MEDIUM SOFT

Have you ever had gum treatment? YES NO

Do your gums bleed? YES NO

Do your gums itch? YES NO

Have you ever had periodontal disease? YES NO

Do you now or have you ever experienced pain/ discomfort in your jaw (TMJ/TMD) ? YES NO

Are your teeth sensitive to heat, cold, or anything else?

Do you have loose teeth? YES NO

Do you still have your wisdom teeth? YES NO

Would you like fresher breath? YES NO

Brighter teeth? YES NO

Are you happy with the way your smile looks:
If NOT, what would you change?

I understand that the information that I have given is correct to the best of my knowledge, I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office an any changes in my medical status. I authorize the dental diagnosis and treatment, with my informed consent.

Signature (print out and sign) Date:

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY

I verbally reviewed/dental information with the patient herein.
Initials: Date:

Doctor's Comments:

Parent Signature Date:

Dentist Signature Date:

Parent Signature Date:

Dentist Signature Date: