NEW PATIENT INFORMATION FORM

Date:

NAME:

Home phone:

Business phone:

Cell phone:

Referring DDS:

Have you been a patient in one of our offices before? Y or N _____

Did your dentist give you a referral card: Y or N _____

Tooth #_____ Have you ever had root canal therapy on this tooth before? Y or N _____

Discomfort? Y or N _____ IF yes, for how long?

Describe symptoms:

Medical History:

Any allergies to medications? Y or N _____ If yes, please list

Heart Murmur? Y or N _____
Endocarditis? Y or N _____
Hip or Joint replacement: Y or N _____
Pre-Medicate? Y or N _____ If yes, which antibiotic do you take?

Which office were you calling for an appointment ?