New Patient Information

Amit Shah, DDS
Creating Healthier Smiles

Welcome to our practice.

Please take your time to fill out this form completely. The more we learn about you, the better care we are able to provide. We look forward to working with you to maintain a healthy, happy smile.

Patient Information

Patient Number _____

Today's date _____

First name _____ Middle initial _____ Last name _____

I prefer to be called (nickname, etc.) _____ ☐ Male ☐ Female

Address _____ City _____ State _____ ZIP _____

Date of birth _____ Social security no. _____

Home phone (___) ___ - _____ Work phone (___) ___ - _____ Cell phone (___) ___ - _____

Primary contact number (please check one) ☐ Home ☐ Work ☐ Cell Best time to call _____

Fax (___) ___ - _____ E-mail _____ Driver's license no. _____

Employer _____ Occupation _____

Spouse's name _____ Spouse's employer _____

Whom may we thank for referring you? _____

If the patient is a child

School _____ School phone (___) ___ - _____ Grade _____

Dental History

Reason for today's visit _____

Are you currently in pain? ☐ Yes ☐ No

If so, please describe: _____

Do you have any dental problems now? ☐ Yes ☐ No

If so, please describe: _____

Have you ever had trouble with a previous dental treatment? ☐ Yes ☐ No

If so, please describe: _____

Level of anxiety about seeing the dentist: (least) 1 2 3 4 5 (most)

Date of last dental exam _____ Date of last cleaning _____ Date of last full mouth X-rays _____

Procedure(s) done at last dental visit _____

Previous dentist's name _____

City _____ State _____ Phone (___) ___ - _____

Why are you changing dentists? _____

How often do you have dental examinations? _____ How often do you brush your teeth? _____

How often do you floss? _____ What type of bristles do you use? ☐ Hard ☐ Medium ☐ Soft

What other dental aids do you use? (Electric toothbrush, toothpick, etc.) _____

Do you require antibiotics before dental treatment?	☐ Yes	☐ No	Do you have frequent headaches?	☐ Yes	☐ No
Do your gums ever bleed?	☐ Yes	☐ No	Do you clench or grind your teeth?	☐ Yes	☐ No
Have you noticed any mouth odors or bad tastes?	☐ Yes	☐ No	Are your teeth sensitive to heat/cold?	☐ Yes	☐ No
Do you bite your lips or cheeks frequently?	☐ Yes	☐ No	Do you still have your wisdom teeth?	☐ Yes	☐ No