Las Cruces Dental Associates

Las Cruces Dental Associates
2569 East Idaho Ave.
Las Cruces, NM 88011
575-523-1479
www.lascrucesdental.net

New Patient Form

Please fill out all the information to the best of your knowledge. All answers will be kept confidential. If you have any questions, please ask us, and we'll be happy to assist you.	Date: / /	Patient #:

Patient Information

Title:	First Name:	Middle Name:	Last Name:	I prefer to be called:

Sex:	Age:	Date of Birth (mm/dd/yyyy): / /	Marital Status:	Social Security #: - -	Driver's Licence State & #:

Home Phone: - -	Work Phone: - -	Cell Phone: - -	E-mail Address:

Home Address:	City:	State:	ZIP Code:

Employment:	Employer's Name:	Employer's Phone: - -	Occupation:

Employer's Address:	City:	State:	ZIP Code:

Student Status:	School Name (if a full-time student):	Grade:

Best places and times to contact you:	Send appointment reminders via: Text Message Email Mail

Please tell us where you heard about us (check all that apply):

Friend or Relative (name): Newspaper Ad Radio Ad TV Ad
Ad in Mail Saw our Office Insurance Company Our Website
Search Engine (Google, etc.) Other Website:
Other:

Was our website a factor in your decision to visit our practice? Yes No

Name of Spouse (or Parent, if a minor):	Spouse/Parent's Employer:	Spouse/Parent Work Phone: - -	Spouse/Parent Cell Phone: - -

Other family members treated by us:	Additional Comments:

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Emergency Contact

This should be the nearest relative who does not live with the patient.

Title:	First Name:	Last Name:	Relationship to Patient:

Home Phone:	Work Phone:	Cell Phone:	E-mail Address:
- -	- -	- -	

Emergency_Contact Address:	City:	State:	ZIP Code:

Person Responsible for Account

Title:	First Name:	Middle Name:	Last Name:	Relationship to Patient:

Date of Birth (mm/dd/yyyy):	Social Security #:	Driver's Licence State & #:	Holder of Dental Insurance for Patient:
/ /	- -		

Home Phone:	Work Phone:	Cell Phone:	E-mail Address:
- -	- -	- -	

Billing Address:	City:	State:	ZIP Code:

Employment:	Employer's Name:	Employer's Phone:	Occupation:
		- -	

Employer's Address:	City:	State:	ZIP Code:

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Insurance Information

Primary Insurance

Insurance Holder's Name:	Date of Birth (mm/dd/yyyy): / /	Relationship to Patient:	Employer:

Member ID:	Group ID:	Insurance Company Name:	Insurance Company Phone: - -

Insured's SSN:	Insurance Company's Address:	City:	State:	ZIP Code:

Secondary Insurance

Insurance Holder's Name:	Date of Birth (mm/dd/yyyy): / /	Relationship to Patient:	Employer:

Member ID:	Group ID:	Insurance Company Name:	Insurance Company Phone: - -

Insured's SSN:	Insurance Company's Address:	City:	State:	ZIP Code:

Authorization

All of the above information is correct to the best of my knowledge. I authorize use of this form on all my insurance submissions and I authorize the release of information to all my insurance companies. I understand that I am responsible for my bill. I authorize Las Cruces Dental Associates to act as my agent in helping me to obtain payment from my insurance companies. I authorize payment to Las Cruces Dental Associates. I permit a copy of this authorization to be used in place of the original. I give Las Cruces Dental Associates, its employees, and/or other agents express prior consent to contact me at any/all phone numbers, including cell numbers (by phone call or text message) and email addresses, for the purpose of treatment, insurance, or payment.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /

Consent for Treatment

Patient Name:

I hereby authorize the doctor or designated staff to take X-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the dental needs of the above-named patient.

Upon such diagnosis, I authorize the doctor or designated staff to perform all recommended treatment mutually agreed upon by us and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I have read, understood, and agree to the above treatment policy.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /

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Dental History

Previous Dentist

Dentist Name:	Dental Practice Name:	Phone: - -

Address:	City:	State:	ZIP Code:

What did you like about your last dentist?	What caused you to leave your last dentist?

Last Dental Visit

Last Dental Visit (m/y): /	What were you treated for?	Treatment complete? Yes No

What was done at your last dental visit?	Last X-Rays: /	Last Full-Mouth X-Rays: /	Last Cleaning: /

Dental Hygiene

How often do you visit a dentist?	Do you brush your teeth? If yes, how often?	Do you floss? If yes, how often?

Please list other dental hygiene aids (Interplak, toothpicks, etc.) that you use:	Are you interested in regular hygiene cleanings?

Today's Visit

Do you have any dental problems, pain, or discomfort at this time? If yes, please describe:

What is the main reason for your visit today?

Tooth Pain Check-up Cleaning Whitening Cosmetic Dentistry
Sedation Dentistry Restorative Dentistry Other:

What would you like to learn more about?

Whitening Cosmetic Dentistry Sedation Dentistry Implants Bridges Veneers
Dentures Other:

Dental Concerns

Check all that apply.

Teeth

Broken or chipped	Loose/missing filling	Missing teeth	Sensitive to sweets
Crooked	Loose teeth	Mouth sores	Blisters on lips/mouth
Decay	Tooth pain	Sensitive to cold	Orthodontic treatment
Difficulty chewing	Food trap areas	Sensitive to heat	Bad taste in mouth
Discolored	Grinding or clenching	Sensitive when biting	

Gums

Bad breath	Abscessed	Sore	Receding
Red (discolored)	Bleeding	Swollen	Periodontal treatment

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Facial/Jaw Pain

Frequent headaches	Pain in temples	Jaw injury	Pain around ear
Avoid certain foods	Jaw locks open/closed	Head injury	
Popping/clicking	Pain in jaw	Neck injury	

Other Concerns

Smoking/dipping	Orthodontic treatment	Snoring
Biting cheeks or lip	Burning tongue	Teeth straightening
Popping/clicking	Tooth replacement	Retainer
TMJ	Fractured tooth syndrome	Dry mouth
Tooth-colored fillings	CPAP	Wisdom teeth extraction
Wisdom teeth	Implants - Tooth #:	Cosmetics
Nail-biting	Jaw locks open/closed	Smile makeover
Sleep apnea	Stain	Dental phobias
Limited orthodontics	Chew on one side	

Does food tend to get caught between your teeth? If yes, where?

Do you hold foreign objects (pencils, pipe, pins, nails, fingernails, etc.) with your teeth? If yes, what?

Have you ever had:

Check all that apply.

Orthodontic treatment	Periodontal treatment	Your bite adjusted
Oral surgery	Your teeth ground	A bite plate or mouth guard

Any canker sores or cold sores on your lips, tongue, gums, or body

A serious injury to the mouth or head? If yes, please describe including cause:

Ratings

1 2 3 4 5	On a scale of 1-5 (1 bad, 5 good), please rate how you feel your overall dental health is.
1 2 3 4 5	On a scale of 1-5 (1 bad, 5 faithful), over the last ten years, rate how faithfully you have had your teeth cleaned.
1 2 3 4 5	On a scale of 1-5 (1 not sensitive, 5 very sensitive), what is your level of sensitivity to dental procedures?
1 2 3 4 5	On a scale of 1-5 (1 not sensitive, 5 very sensitive), what is your sensitivity to dental cleaning appointments?
1 2 3 4 5	On a scale of 1-5 (1 unhappy, 5 very happy), rate how you feel about the look of your smile.
1 2 3 4 5	On a scale of 1-5 (1 poor, 5 great), how do you rate your quality of sleep?
1 2 3 4 5	On a scale of 1-5 (1 being low, 5 being high), if you snore, how would you rate the severity of your snoring?

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Have you ever had:

Check all that apply.

- Arthritis
- Arteriosclerosis
- Birth defects
- Cancer
- Emotional problems
- Head or face injury
- Heart murmur/trouble
- History of substance abuse/drug addiction
- Kidney problems
- Numbness of arms or hands
- Swollen, still painful joints
- Allergies
- Asthma
- Blood disease
- Diabetes
- Endocrine problems
- Intestinal disorders
- Hepatitis A, B, or C
- Hypertension (high blood pressure)
- Liver problems
- Pneumonia
- Shortness of breath
- Anemia
- Bruise easily
- Dizziness
- Epilepsy
- Seizures
- Fainting
- Hearing disorders
- High or low blood sugar
- Hypotension (low blood pressure)
- Nervous disorder
- Rheumatic fever
- Heart attack/stroke
- Heart surgery
- Pacemaker
- Artificial valves
- Congenital heart defect
- Mitral valve prolapse
- Artificial bones/joints
- Shingles
- HIV/AIDS
- Blood transfusions
- Fever blisters
- Sinus problems
- Severe/frequent headaches
- Cancer/chemotherapy
- Radiation treatments
- Psychiatric problems
- Tuberculosis
- Venereal disease
- Hemophilia
- Abnormal bleeding
- Ulcers/colitis
- Difficulty breathing
- Hospitalized for any reason
- Emphysema
- Glaucoma
- Thyroid disease
- Angina
- Artificial hip/joints
- Gout
- Chest pain
- Circulatory problems
- Cold sores
- Congenital heart lesion
- Cortisone medicine
- Convulsions
- Herpes
- Leukemia
- Excessive thirst
- Hay fever
- Heart disease
- Hives/skin rash
- Hypoglycemia
- Irregular heartbeat
- Lung disease
- Osteoporosis
- Pain in jaw joints
- Parathyroid disease
- Recent weight loss
- Rheumatism
- Scarlet fever
- Sexually transmitted disease
- Sickle cell anemia
- Sinus trouble
- Tattoos/body piercing
- TMD/TMJ (jaw pain)
- X-ray or cobalt treatment
- Yellow jaundice
- Chronic fatigue syndrome
- Cough-persistent or bloody
- Latex sensitivity
- Smoker
- Swelling of feet/ankles
- Swollen neck glands
- Tonsillitis
- Tumor or growth on head/neck
- Easily winded
- Anaphylaxis
- Alzheimer's disease
- Frequent diarrhea
- Genital herpes
- Renal dialysis
- Spina bifida

Have you ever had an adverse reaction or allergies to any medication or substance?

Check all that apply.

- Acrylic
- Aspirin
- Barbiturates (sleeping pills)
- Codeine
- Dental anesthetics
- Erythromycin
- Iodine
- Latex rubber
- Metals
- Nitrous oxide
- Novocaine
- Penicillin/antibiotics
- Sedatives
- Sulfa drugs
- Tetracycline
- Valium
- Xylocaine