COMMUNITY ACTION
TRI-COUNTY CAP
Serving Coös, Carroll & Grafton County since 1965

TamworthDental
A TRI-COUNTY COMMUNITY ACTION PROGRAM, INC.
448 B White Mountain Hwy, Tamworth, NH 03886 603-323-7645 (323-SMILE)

# Tamworth Dental Center New Patient Form

Please print & fill out completely

## Patient Information

Name:______________________ Birth Date: ____________ Sex: ☐ Male ☐ Female
Address:______________ City: ____________ State: ____________ Zip Code:____________
Cell Phone:______________ Home Phone:______________ Work Phone:____________
Email:______________ Occupation/Employer:______________ Marital Status: ☐ Single ☐ Married
Emergency Contact:______________ Relationship to Patient:______________ Phone:____________
Ethnicity (optional):______________ How were you referred to our practice?____________
Who is responsible for your payment if different from above?____________
Address:______________ City: ____________ State: ____________ Zip Code:____________
Cell Phone:______________ Email:______________ Birthdate:____________

## Dental Insurance Information

Insurance Company:______________ Phone Number: ____________
Subscriber's Name:______________ Subscriber's SSN:____________
Group Number:______________ Employer: ID#: ____________

## Secondary Dental Insurance Information (if applicable)

Insurance Company:______________ Phone Number: ____________
Subscriber's Name: ______________ Subscriber's SSN: ____________
Group Number:______________ Employer: ID#: ____________

## Dental History

Reason for today's visit:____________
Are you experiencing any dental pain today? ☐ YES ☐ NO
Former dentist name/practice:______________ Phone: ____________
Date of last dental exam:______________ Date of last cleaning:____________
Date of last bitewing radiographs:______________ Date of last full mouth series of radiographs:____________
How often do you brush?______________ How often do you floss?____________

| Question | | | Question | | |
|---|---|---|---|---|---|
| Do you wear dentures or partials? | YES | NO | Any serious injury to your head or mouth? | YES | NO |
| Have you had periodontal treatment? | YES | NO | Sensitivity to hot/cold/sweets/ or biting? | YES | NO |
| Have you had orthodontic treatment? | YES | NO | Do your gums bleed? | YES | NO |
| Have you had any oral surgery/implants? | YES | NO | Any loose teeth, broken fillings? | YES | NO |
| Do you have pain, popping, clicking of your jaw? | YES | NO | Any sores or growths in your mouth? | YES | NO |
| Has a physician or previous dentist recommended that you take an antibiotic prior to dental treatment? | | | | YES | NO |

## Medical History

Name of Primary Care Physician:______________ Date of last visit: ____________
Have you ever had any serious illness or operations?:____________
Has there been any change in your general health within the past year or are you being treated for a condition now? ☐ YES ☐ NO If YES, Please Explain:____________
Please list all Allergies:____________
Medical Insurance Company:______________ Subscriber ID#: ____________

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**Please circle Yes or No (Y or N) for any illnesses that you currently have or have had in the past.**

| Heart/Blood Disorders | | |
|---|---|---|
| Artificial Heart Valves | Y | N |
| Anemia | Y | N |
| Angina | Y | N |
| Abnormal Bleeding | Y | N |
| Bacterial Endocarditis | Y | N |
| Blood Transfusion | Y | N |
| Circulatory Problems | Y | N |
| Congenital Heart Defects | Y | N |
| Congestive Heart Failure | Y | N |
| Coronary Artery Disease | Y | N |
| Heart Attack | Y | N |
| Heart Murmurs | Y | N |
| Heart Surgery | Y | N |
| Hemophilia | Y | N |
| High Blood Pressure | Y | N |
| Low Blood Pressure | Y | N |
| Methemoglobinemia | Y | N |
| Mitral Valve Prolapse | Y | N |
| Pacemaker/Defibrillator | Y | N |
| Prosthetic Heart Valve | Y | N |
| **Neurological Disorders** | | |
| Epilepsy | Y | N |
| Migraine | Y | N |
| Stroke | Y | N |

| Immune System Disorders | | |
|---|---|---|
| Allergies | Y | N |
| Myasthenia Gravis | Y | N |
| Rheumatoid Arthritis | Y | N |
| Sjogren's Syndrome | Y | N |
| Systemic Lupus | Y | N |
| **Infectious Diseases** | | |
| AIDS/HIV | Y | N |
| Hepatitis | Y | N |
| Sexually Transmitted Disease | Y | N |
| **Other Conditions** | | |
| Artificial Joints<br>Type: ____________ | Y | N |
| Cancer/Chemotherapy/Radiation | Y | N |
| Chronic Pain | Y | N |
| Glaucoma | Y | N |
| Kidney Problems/Dialysis | Y | N |
| Liver Disease | Y | N |
| Osteoporosis:<br>Have you taken Bisphosphonates?<br>YES NO | Y | N |
| Pregnancy/Nursing | Y | N |
| Sleep Apnea | Y | N |
| **Hormonal or Metabolic Disorders** | | |
| Diabetes: Type I or II | Y | N |
| Thyroid Problem | Y | N |

| Behavioral Conditions | | |
|---|---|---|
| Anxiety/Panic Attacks | Y | N |
| Eating Disorder | Y | N |
| Mental Health Disorder | Y | N |
| **Substance Use** | | |
| Alcohol Use | Y | N |
| Marijuana Use | Y | N |
| Tobacco Use<br>Type: ____________ | Y | N |
| Vaping/Juuling | Y | N |
| Any other controlled substance use (Please list):____________ | Y | N |
| **Respiratory/ Lung Conditions** | | |
| Asthma | Y | N |
| Bronchitis/Tonsillitis | Y | N |
| Emphysema/COPD | Y | N |
| Fainting | Y | N |
| History of Tuberculosis | Y | N |
| **Gastrointestinal Disorders** | | |
| G.E. Reflux/Heartburn | Y | N |
| Inflammatory Bowel Disease | Y | N |
| Ulcers/Gastritis | Y | N |
| **Additional/Other Conditions** | | |
| Please list any other conditions not mentioned above: ____________<br>____________ | | |

**Please list any medications that you are taking now. Include non-prescription medications, vitamins/ supplements:**

| Name of Medication | Dose | Reason for taking |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I (or my minor child) has any change in health.**

____________ ____________ ____________

Signature Print Name Date

**If you are completing this form for another person, what is your name and relationship to the patient?**

Name: ____________ Relationship: ____________