NEW PATIENT INFORMATION

Richard S. Butler, DDS, PA & Associates

Welcome to our practice! We are committed to excellence in dentistry & appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us - we will be happy to help. (We are required to ask the starred questions by the State of NC)

ABOUT YOU (*Patient*):

[ ] Child, [ ] Single, [ ] Married, [ ] Other ______________________

Gender: [ ] Male [ ] Female [ ] Other ______________________

Race*:[ ] Asian, [ ] Black, [ ] Hispanic, [ ] Native American, [ ] Pacific Islander, [ ]White, [ ] Other ______________________

Native Language *: ________________

Name: ______________________________________ **I prefer to be called**____________________

Birth date: _______/_______/________ **Age**: __________ **S.S. #**: _________________________________

Address: ____
Street

____
City *State* *Zip*

Home Phone: (_____) ________________ **Mobile**: (_____) _______________ **E-mail**: ____

Employer: ____ **Work Phone**: (_____) _________________ **Best way to contact**:__________

RESPONSIBLE PARTY (*If Patient is a child/dependent OR if someone other than Patient is paying for treatment*):

[ ] Not Applicable ***Are we permitted to speak with this person about your dental treatment? [ ] Yes [ ] No***

Name: ____ Relation to patient: ____________________Birth date: _______/_______/________

SS# : ______________________________ **Address**: ____
Street *City* *State* *Zip*

Main Phone: (______) ________________ Employer: ____ Work Phone: (______) ________________

SPOUSE INFORMATION:

[ ] Not Applicable ***Are we permitted to speak with this person about your dental treatment? [ ] Yes [ ] No***

Name: ____ Birth date: _______/_______/_______ Phone Number: _____________________

DENTAL INSURANCE INFORMATION:

[ ] NO DENTAL INSURANCE

Primary Insurance	**Secondary Insurance** (***if applicable***)
Insurance Co. Name: ____	Insurance Co. Name: ____
Phone: (_______) _____________________	Phone: (_______) _____________________
Policy #: _________________________ Group #:________________	Policy #: _________________________ Group #:________________
Insured's Name: __________________________	Insured's Name: __________________________
Insured's Birth date: ______/______/_______ Relation: ____________	Insured's Birth date: ______/______/_______ Relation: ____________
Insured's Social Security #: ___________________________	Insured's Social Security #: ___________________________
Insured's Employer: ____	Insured's Employer: ____

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PRIMARY PHYSICIAN ______________________ OFFICE PHONE ______________ DATE OF LAST EXAM __________

PHARMACY YOU USE ______________________ PHONE and/or LOCATION ______________ HEIGHT* ________ WEIGHT* ________

	YES	NO
1. Are you under medical treatment now?	[ ]	[ ]
2. Have you ever been hospitalized for any surgical operation or serious illness ?	[ ]	[ ]
3. Are you taking any medication(s) including non-prescription medicine?	[ ]	[ ]

If yes, what medication(s) are you taking?

____

____

	YES	NO
4. Do you use tobacco?	[ ]	[ ]

If Yes, please specify type: ______________

If Yes, please specify frequency of use: ______________

____

6. Are you allergic to or have you had any reactions to the following?

YES	NO		YES	NO		YES	NO	
[ ]	[ ]	Local anesthetics (ie: novocaine)	[ ]	[ ]	Barbiturates	[ ]	[ ]	Aspirin
[ ]	[ ]	Penicillin or other antibiotics	[ ]	[ ]	Sedatives	[ ]	[ ]	LATEX
[ ]	[ ]	Sulfa Drugs	[ ]	[ ]	Iodine	[ ]	[ ]	Other ________ ________

7. WOMEN ONLY:	YES	NO
a) Are you pregnant or think you may be pregnant?	[ ]	[ ]
b) Are you nursing?	[ ]	[ ]
c) Are you taking birth control pills?	[ ]	[ ]
d)Are you or have you ever taken a drug known as a bisphosphonate (ie: Boniva, Fosamax, Zometa)?	[ ]	[ ]

8. Do you have or have you had any of the following?

YES	NO		YES	NO		YES	NO		COMMENTS
[ ]	[ ]	High Blood Pressure	[ ]	[ ]	Stroke	[ ]	[ ]	Diabetes Type 1	
[ ]	[ ]	Low Blood Pressure	[ ]	[ ]	Epilepsy/Seizures	[ ]	[ ]	Diabetes Type 2	______________
[ ]	[ ]	Heart Disease	[ ]	[ ]	Fainting	[ ]	[ ]	Swollen Ankles	
[ ]	[ ]	Cardiac Pacemaker	[ ]	[ ]	Liver/Kidney Disease	[ ]	[ ]	Rapid Weight Loss/Gain	______________
[ ]	[ ]	Heart Attack	[ ]	[ ]	Jaundice	[ ]	[ ]	Stomach Ulcers	
[ ]	[ ]	Heart Murmur	[ ]	[ ]	Asthma	[ ]	[ ]	Acid Reflux	______________
[ ]	[ ]	Angina/Chest Pains	[ ]	[ ]	Emphysema	[ ]	[ ]	Eating Disorder	
[ ]	[ ]	Mitral Valve Prolapse	[ ]	[ ]	Easily Winded	[ ]	[ ]	Arthritis	______________
[ ]	[ ]	Prosthetic Heart Valve	[ ]	[ ]	Hay Fever/Allergies	[ ]	[ ]	Joint Replacement	
[ ]	[ ]	Rheumatic Fever	[ ]	[ ]	Tuberculosis	[ ]	[ ]	Implant(s)/Pins	______________
[ ]	[ ]	Anemia	[ ]	[ ]	Hepatitis	[ ]	[ ]	Osteoporosis	
[ ]	[ ]	Cancer	[ ]	[ ]	STD	[ ]	[ ]	Glaucoma	
[ ]	[ ]	Radiation Therapy	[ ]	[ ]	HIV/AIDS				
						[ ]	[ ]	Other	______________

PATIENT DENTAL HISTORY

PREVIOUS DENTIST ______________________ OFFICE PHONE ______________ DATE OF LAST EXAM __________

	YES	NO
1. Do your gums bleed while brushing or flossing?	[ ]	[ ]
2. Are your teeth sensitive to hot or cold liquids/foods?	[ ]	[ ]
3. Are your teeth sensitive to sweet or sour liquids/foods?	[ ]	[ ]
4. Do you feel any pain to any of your teeth?	[ ]	[ ]
5. Do you have any sores or lumps in or near your mouth?	[ ]	[ ]
6. Have you had any head, neck or jaw injuries?	[ ]	[ ]
7. Have you ever experienced any of the following problems in your jaw?		
a) Clicking?	[ ]	[ ]
b) Pain (joint, ear, side of face)?	[ ]	[ ]
c) Difficulty in opening or closing?	[ ]	[ ]
d) Difficulty in chewing?	[ ]	[ ]

	YES	NO
8. Do you have frequent headaches?	[ ]	[ ]
9. Do you clench or grind your teeth?	[ ]	[ ]
10. Do you bite your lips or cheeks frequently?	[ ]	[ ]
11. Have you ever had any difficult extraction(s) in the past?	[ ]	[ ]
12. Have you ever had any prolonged bleeding ? following extraction(s)?	[ ]	[ ]
13. Have you ever had any orthodontic treatment?	[ ]	[ ]
14. Have you ever had periodontal treatment?	[ ]	[ ]
15. Have you ever had instructions on the care of your gums?	[ ]	[ ]
16. Have you ever had instruction on the correct method of brushing your teeth?	[ ]	[ ]

APPOINTMENT AGREEMENT

We value your time as a patient, and make every effort to stay on or ahead of our schedule. We reserve your appointment time ***especially for you***. Therefore, we need ***your*** help in keeping us on schedule, so you and other patients are not kept waiting. Patients arriving late for an appointment, may have to be rescheduled. Please bear in mind that a missed appointment hurts you, other patients, and our practice. If you are not able to keep your appointment for any reason, our request is to have at least 24 hours advance notice. We reserve the right to assess a **$50.00** fee to all of our patients for missed appointments for **failure** to give **24 hours** advance notice. Thank you for your help in this matter.

I certify that I have read and understand the above information. To the best of my knowledge, all questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I have had an opportunity to read the office privacy policy*.

SIGNATURE X______________________________ ______________

PATIENT, PARENT OR GUARDIAN DATE