New Patient Information

Blaine G. Calahan, DDS, MS
Amber Kreko, DDS, MS

Chris B. Gardner, DDS, MHS
Jack O'Neill, DMD

We are committed to excellence in dentistry and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have questions or need assistance, please ask us – we will be happy to help.

Whom may we thank for referring you? _____

ABOUT YOU

Name:_____ I prefer to be called _____ [ ] Male [ ] Female

Birth Date:____/____/____ Age:_____ DL #:_____ S.S.#: _____

Home Address:_____ City_____ State_____ Zip _____

Home Ph: (____)_____ Work Ph: (____)_____ Cell Ph: (____) _____

Email: _____

Employer:_____ How long there?_____ Occupation: _____

Employer's Address:_____ City_____ State_____ Zip _____

PERSON RESPONSIBLE FOR ACCOUNT

[ ] Same as above Name:_____ Birth Date:____/____/____ Relation: _____

Billing Address:_____ City_____ State_____ Zip _____

Home Ph: (____)_____ Work Ph: (____)_____ S.S. #: _____

Employer:_____ How long there?_____ Occupation: _____

SPOUSE / PARENT / EMERGENCY CONTACT INFORMATION

[ ] Same as above Name:_____ Birth Date:____/____/____

Employer _____ Work Ph: (____)_____ ext. _____

DENTAL INSURANCE INFORMATION

Primary Insurance

Insurance Co. Name:_____ Phone: (_____)_____ Group/Policy #: _____

Insured's Name: _____ Insured's Birth Date:____/____/____ Relation: _____

Insured's Social Security #:_____ Insured's Employer: _____

Secondary Insurance

Insurance Co. Name:_____ Phone: (_____)_____ Group/Policy #: _____

Insured's Name: _____ Insured's Birth Date:____/____/____ Relation: _____

Insured's Social Security #:_____ Insured's Employer: _____

PERSONAL ORAL CARE

How often do you have your teeth cleaned by a dentist or hygienist?_____ Last time? _____

Do you know what dental/bacterial plaque is? [ ] Yes [ ] No How often do you brush your teeth? _____

What do you use to clean in-between your teeth? _____

Specify other cleaning aids used: _____

ORAL HISTORY

Chief dental concerns: _____

Have you ever had any previous periodontal (gum) treatment?	[ ] YES	[ ] NO
Do your gums ever bleed when you brush your teeth?	[ ] YES	[ ] NO
Are your gums receding?	[ ] YES	[ ] NO
Are your teeth hypersensitive to cold/hot or sweets?	[ ] YES	[ ] NO
Have you noticed drifting and/or loosening of your teeth?	[ ] YES	[ ] NO
Have you ever had your teeth straightened with orthodontics?	[ ] YES	[ ] NO
Do you often find yourself clenching and/or grinding your teeth?	[ ] YES	[ ] NO
Have you ever had a bad reaction to dental anesthetic?	[ ] YES	[ ] NO
Have you ever had any complications following dental surgery?	[ ] YES	[ ] NO
Do you have any anxieties about dental procedures?	[ ] YES	[ ] NO

MEDICAL HISTORY INFORMATION

Name of Physician: _____ Phone: (_____) _____

What is your preferred pharmacy? _____

Do you have or have you ever had any of the following? Please check all that apply:

[ ] Alcohol/Drug Dependency
[ ] Allergies/Hay Fever
[ ] Anemia/Bleeding Problems
[ ] Angina
[ ] Arthritis
[ ] Artificial Joints/Valves
[ ] Asthma
[ ] Birth Control
[ ] Cancer
[ ] Chemo/Radiation
[ ] COVID-19
[ ] Diabetes A1C_____
[ ] Epilepsy or Seizures
[ ] Fainting or Dizziness
[ ] Fever Blisters/Cold Sores
[ ] Frequent Cough
[ ] Glaucoma
[ ] Heart Trouble
[ ] Hepatitis
[ ] High Blood Pressure
[ ] HIV/AIDS
[ ] Kidney Problems
[ ] Liver Problems
[ ] Mental Disorders
[ ] Mitral Valve Prolapse
[ ] Osteoporosis
[ ] Respiratory Illness
[ ] Rheumatic Fever
[ ] Rheumatoid Arthirtis
[ ] Sinus Problems
[ ] STD
[ ] Stroke
[ ] Surgical Shunt
[ ] Thyroid Problems
[ ] Tuberculosis
[ ] Ulcers
[ ] Taking Blood Thinners

YES NO

[ ] [ ] Do you have any health problems that were not listed above or need further clarifications? If yes, explain:

_____

[ ] [ ] Are you currently under the care of a physician? If yes, explain:

_____

[ ] [ ] Have you been admitted to a hospital or needed emergency care during the past two years? If yes, explain:

_____

[ ] [ ] Are you taking any medications or herbals? If yes, list:

_____

_____

_____

[ ] [ ] Are you allergic to any medications or substances? If yes, please check box below:

[ ] Latex [ ] Penicillin [ ] Codeine [ ] Other _____

[ ] [ ] Have you used tobacco? If yes, explain: _____

WOMEN (Please check): [ ] Pregnant [ ] Trying to get pregnant [ ] Nursing [ ] Taking oral contraceptives

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I will inform the dentist and the staff at the next appointment without fail. I hereby authorize the release of any dental records, x-rays or other pertinent medical or dental information to Dr. Calahan/Dr. O'Neill/Dr. Gardner/Dr. Kreko or any other consulting physician or dentist.

Signature of patient/parent or guardian: _____ Date: _____