New Century Dental Care

Gateway Plaza 1520 N Mountain Ave #123 Ontario, CA. 91762
Phone: 909-988-9690

Thank you for giving us the opportunity to serve your dental healthcare needs.
*Our dental team's priority is to **always** provide you with an exceptional dental experience!*

Patient's Information

First Name _____ Middle I ____ Last Name _____

Date of Birth _____ Male☐ Female ☐ Single☐ Married☐ Divorced☐ Widowed☐

Address _____ Appt# _____

City _____ State_____ Zip Code _____

Home Phone _____ Cell # _____ E-Mail _____

Employer _____ Occupation _____

Address _____ Suite# _____ Work Phone _____

City _____ State _____ Zip Code _____

Emergency Contact _____ Contact Phone_____

Relationship to Patient _____

Referral Information

Whom may we thank for referring you to *New Century Dental Care?*

Saw Sign☐ Yellow Pages☐ Internet ☐ Insurance Carrier☐ Mail☐ Doctor's Office☐
Friend/Relative☐ Name _____

Responsible Party Information (If Other Than Patient)

First Name _____ Middle I ____ Last Name _____

Date of Birth _____ Male☐ Female ☐ Single☐ Married☐ Divorced☐ Widowed ☐

Address _____ Appt# _____

City _____ State_____ Zip Code _____

Home Phone _____ Cell # _____ E-Mail _____

Dental Insurance Information

Insurance Company _____ Employer _____

Name of Insured _____ DOB _____ SS#/ID# _____

Relationship to Patient _____ Group/Policy# _____

Is there any additional dental insurance? ☐Yes ☐ No

Insurance Company _____ Employer _____

Name of Insured _____ DOB _____ SS#/ID# _____

Relationship to Patient _____ Group/Policy# _____

New Century Dental Care

Confidential Dental History

Patient Name _____ **Date** _____

Please describe the primary reasons for your visit (concerns):

1. _____
2. _____
3. _____

Date of last dental exam _____ Date of last X-Rays _____ Date of last dental cleaning _____
Former Dentist _____ Phone _____

If you left your previous dentist, what are the reasons? _____

Have you had problems with prior dental treatment? _____

What concerns do you currently have with your oral health? (*Please circle Yes or No for each*)

Does your gum bleed when you brush or floss? Yes / No
How often do you brush? _____
How often do you floss? _____
Are your teeth sensitive to cold, hot, sweets or pressure? Yes / No
Does food or floss catch between your teeth? Yes / No
Do you have dry mouth / bad breath? Yes / No
Do you have earaches or neck pains? Yes / No
Do you have any clicking, popping or discomfort in the jaw? Yes / No
Do you clench or grind your teeth? Yes / No
Do you have sores or ulcers in your mouth? Yes / No
Are you currently experiencing dental pain? Yes / No

Have you had any gum surgery? Yes / No If yes, when _____
Have you ever had Orthodontic treatment? Yes / No If yes, when _____

If you could rate your smile 1-10, what would it be? _____
Would you like to improve your smile? Yes / No

Are you interested in learning more about the following? (check all that apply)

- ☐ Teeth whitening
- ☐ Orthodontic treatment
- ☐ Veneers
- ☐ Tooth-colored fillings
- ☐ Metal-free crowns
- ☐ Dental implant
- ☐ How to prevent gum disease
- ☐ At-home oral hygiene care
- ☐ Gum treatment during pregnancy
- ☐ Oral hygiene care for infants and toddlers

DOCTOR'S NOTES: _____

_____

Confidential Health History Form

Patient Name _____ **Date** _____

Physician's name _____ Phone number _____ Last visit date _____

	Yes	No	
Have you ever been hospitalized?	☐	☐	Please explain _____
Have you ever had a serious head or neck injury?	☐	☐	Please explain _____
Do you smoke and/or use tobacco products?	☐	☐	How often _____
Are you taking any medications?	☐	☐	Please list name(s) _____

Are you taking or scheduled to begin taking bisphosphonates such as Alendronate (Fosamax), Risedronate (Actonel), Aredia or Zometa for osteoporosis, bone pain, hypercalcemia or skeletal complications resulting from Paget's Disease, Multiple Myeloma or Metastasic Cancer? Yes No

Are you **allergic** to any of the following? Aspirin☐ Penicillin or Other Antibiotics☐ Sulfa Drugs☐ Codeine☐ Latex☐
Local Anesthetics☐ Metals☐ Other Allergies☐ Please specify _____

Women Only (*Please check box if* ***Yes***) **Are you?** Pregnant ☐ Taking Birth Control ☐ Nursing ☐

Do you have, or ever had a history of: (*Please circle Yes or No)*

AIDS/HIV Positive	Yes / No	Stroke	Yes / No	Joint replacement	Yes / No
Sexually transmitted disease	Yes / No	Cancer	Yes / No	Implant	Yes / No
Blood transfusion	Yes / No	Chemotherapy	Yes / No	Epilepsy/Seizures	Yes / No
Blood disease/Anemia	Yes / No	Radiotherapy	Yes / No	Glaucoma	Yes / No
Bleeding problems	Yes / No	Tumors/Growths	Yes / No	Arthritis	Yes / No
Hemophilia	Yes / No	Liver disease or Hepatitis	Yes / No	Rheumatism	Yes / No
Angina (Chest pain)	Yes / No	Diabetes Type I or II	Yes / No	Frequent Headaches	Yes / No
Arteriosclerosis	Yes / No	Drug/Alcohol abuse	Yes / No	Migraine	Yes / No
Heart disease/Attack	Yes / No	Lung disease/Bronchitis	Yes / No	Sinus problems	Yes / No
Heart murmur	Yes / No	Tuberculosis	Yes / No	Special diet	Yes / No
Mitral valve prolapse	Yes / No	Asthma	Yes / No	Recent weight loss	Yes / No
Artificial heart valve	Yes / No	Shortness of breath	Yes / No	Stomach problems	Yes / No
Rheumatic Fever	Yes / No	Emphysema	Yes / No	Acid Reflux	Yes / No
Pacemaker	Yes / No	Kidney disease/failure	Yes / No	Autism	Yes / No
Rheumatic heart disease	Yes / No	Thyroid disease	Yes / No	Psychiatric care	Yes / No
High blood pressure	Yes / No	Lupus	Yes / No	Mental Health Disorders	Yes / No
Low blood pressure	Yes / No	Osteoporosis	Yes / No		

Please list any other medical condition not mentioned above _____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_____ _____

Patient /Responsible Party Signature **Date** **Dentist Signature** **Date**

Doctor's Comments _____