UNION
SQUARE
DENTAL
PRACTICE

New Patient Form

Primary Information

Full Name _____ Nickname _____ Sex ☐ F ☐ M

Date of Birth _____ Social Security Number _____

Occupation _____ Employer _____

Home address _____ Home phone _____

Business address _____ Business phone _____

Email address _____ Cell phone _____

Insurance Information

Do you have a dental insurance coverage? ○ YES ○ NO

Primary Insurance

Name of Policy Holder _____ ID | SSN _____ DOB _____

Insurance Company _____ Group No. _____ Relationship to Patient _____

Secondary Insurance

Name of the Policy Holder _____ ID | SSN _____ DOB _____

Insurance Company _____ Group No. _____ Relationship to Patient _____

Getting to Know You

Whom may we thank for referring you to our office? _____

Is another person you know a patient in our office? _____ Relationship _____

Person to contact in case of emergency _____ Relationship _____

Address _____ Phone Number _____

I hereby authorize payment to the above dentist of the group dental benefits, otherwise payable to me but not to exceed the charges shown on the claim. I understand I am financially responsible for any charges not covered by my insurance or by this authorization.

Signature of Patient _____ Date _____

Signature of Parent or Guardian _____ Date _____

Name of Parent or Guardian _____ Relationship _____

450 Sutter Street
Suite 1326
San Francisco, CA
94108–3902

T 415.693.9139
UnionSquareDental.com

UNION
SQUARE
DENTAL
PRACTICE

Dental History

What is the reason for your visit today?

Date of last dental visit | Last dental cleaning | Last full-mouth x-rays

What was done on your last dental visit?

How often do you brush your teeth? | How often do you floss your teeth?

What other dental aids do you use?

Previous Dentist's Name | Phone Number

Address

Are any of your teeth sensitive to:

Hot or cold	○ YES	○ NO
Sweets	○ YES	○ NO
Biting or chewing	○ YES	○ NO
Have you noticed any mouth odors	○ YES	○ NO
Your teeth ground or the bite adjusted	○ YES	○ NO
Do you have bad taste in your mouth	○ YES	○ NO
Do you frequently get cold sore or any other oral lesions	○ YES	○ NO

Do your gums bleed or hurt?

Have your parents experienced gum disease or tooth loss?	○ YES	○ NO
	○ YES	○ NO
Have you noticed any loose teeth or change in your bite?	○ YES	○ NO
Does food tend to become caught in between your teeth?	○ YES	○ NO

Do you:

Clench or grind your teeth	○ YES	○ NO
Bite your lips or cheeks regularly	○ YES	○ NO
Hold foreign objects with your teeth?	○ YES	○ NO
Have you noticed any mouth odors	○ YES	○ NO
Mouth breathe while awake or asleep	○ YES	○ NO
Have tired jaws in the morning	○ YES	○ NO
Smoke/Chew tobacco	○ YES	○ NO

Have you ever had:

Orthodontic treatment	○ YES	○ NO
Oral Surgery	○ YES	○ NO
Periodontal treatment	○ YES	○ NO
Your teeth ground or the bite adjusted	○ YES	○ NO
A bite plate or mouth guard	○ YES	○ NO
A serious injury to the mouth or head	○ YES	○ NO

If yes

Have you ever experienced:

Clicking or popping of the jaw	○ YES	○ NO
Pain (joint, ear, side of face)	○ YES	○ NO
Difficulty in opening or closing the mouth	○ YES	○ NO
Headaches, neck or shoulder ache	○ YES	○ NO
Sore muscles (neck, Shoulder)	○ YES	○ NO
Difficulty in chewing	○ YES	○ NO
Feel satisfied with your teeth appearance?	○ YES	○ NO
Feel nervous about dental treatment?	○ YES	○ NO

If so, what if your biggest concern?

Have you ever had an upsetting dental visit? If yes, ○ YES ○ NO

On a scale of 1 to 10, 10 being perfectly healthy teeth, please rate your own teeth.

Is there anything you would like to change in your teeth appearance?

Is there anything else about having dental treatment that you would like us to know?

Signature of Patient | Date

Signature of Doctor | Date

450 Sutter Street
Suite 1326
San Francisco, CA
94108–3902

T 415.693.9139
UnionSquareDental.com

UNION
SQUARE
DENTAL
PRACTICE

Health History

Full Name _____ Date of Birth _____

O YES O NO Are you in good health?

O YES O NO Has there been any changes in your health within last year?

O YES O NO Have you had problems with prior dental treatment? If Yes, explain

O YES O NO Are you in pain now? If Yes, please explain

O YES O NO Are you, or could you be pregnant? If Yes, what month _____ Are you Nursing? O YES O NO

O YES O NO Are you under a care of a physician? Date of last physical exam

Physician's Name _____ Phone Number _____

Address _____

Have you had or do you have any of the following?

- O Heart disease, defects
- O AIDS/HIV
- O Psychiatric care
- O Transplant
- O Heart attack
- O Stroke
- O Heart murmur
- O Tumors or cancer
- O Joint replacement
- O Damaged heart valves
- O Diabetes
- O Chemotherapy
- O Congestive heart failure
- O Gastrointestinal disease
- O Radiation
- O Pace maker
- O Eating disorder
- O Arteriosclerosis
- O High Blood pressure
- O Ulcers
- O Recurrent infection
- O Abnormal bleeding
- O Thyroid disorder
- O Osteoporosis
- O Lung disease or Emphysema
- O Kidney or bladder disease
- O Liver disease
- O Tuberculosis
- O Hepatitis
- O Arteriosclerosis
- O Asthma
- O Sexually transmitted disease
- O Herpes
- O Anemia
- O Seizure, Epilepsy
- O Sinus problems
- O Damaged heart valves
- O Chronic pain
- O Fainting spells
- O Chest pain upon exertion
- O Rheumatism/arthritis

Please list all medications you are taking, including over the counter, herbal, alcohol, and recreational drugs.

Are you allergic to any medication?

Do you have any disease or condition not listed above?

Has a physician or previous dentist recommended that you take antibiotics before dental treatment?

Is there any issue or condition that you would like to discuss with the dentist in private?

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes in my health and/or medication. Further, I will not hold my dentist, or any other member of the staff, responsible for any errors or omissions that I made have made in completion of this form. I also authorize the dentist to contact my physician.

Signature of Patient, Parent, or Guardian _____ Date _____

Signature of Doctor _____ Date _____

450 Sutter Street
Suite 1326
San Francisco, CA
94108–3902

T 415.693.9139
UnionSquareDental.com

UNION
SQUARE
DENTAL
PRACTICE

Consent For Treatment

I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a through diagnosis of dental need of.

Name of Patient

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon me to employ such assistance as required to provide proper care.

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

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payment are not received by agreed upon dates, I understand that if the payment is not received by 60 days after due date, my account is subjected to be sent to collection company.

Appointment time is reserved especially for you. In the event you need to change a scheduled appointment, we ask you please give us two business days notice. We understand emergencies do arise but in case of non-emergency cancellation, a cancellation fee will be charged to your account.

Signature of Patient ..... Date .....

Signature of Parent or Guardian ..... Date .....

Name of Parent or Guardian ..... Relationship .....

450 Sutter Street
Suite 1326
San Francisco, CA
94108–3902

T 415.693.9139
UnionSquareDental.com

PRINT SUBMIT