PATIENT INFO

Legal Name ______________________ Preferred Name ______________________ DOB__________ SSN__________

Mailing Address ______________________________________ City__________________ ST_____ Zip__________

Cell #______________ Home # ______________ Email______________________ Preferred Contact ☐ Email ☐ Cell ☐ Text

Employer______________________ Occupation__________________ Work Phone __________________

If minor, parent's names__________________________________ Emergency Contact Phone__________________

BILLING INFO

☐ Not Currently Covered By Insurance

Primary Insurance Carrier______________________ Group #__________ *(present primary insurance card at front desk)*

Account Holder: Name__________________ SSN______________ DOB__________ Relationship to Patient __________

Secondary Insurance Carrier *(if applicable)* ______________________ Group #__________ *(present secondary insurance card at front desk)*

REFERRAL

☐ Ask us how you can earn rewards through our referral program!

How did you hear about us? ☐ Friend/Family Member ☐ Other Doctor ☐ Google ☐ Yelp ☐ Holistic Search ☐ Insurance ☐ Website ☐ Drive-by

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

MEDICAL HISTORY

Please check any that apply... ☐ Dog Allergy ☐ Fear of Dogs

☐ Cancer/Tumor ☐ Rheumatic Fever ☐ Artificial Joint/Valve/Pacemaker ☐ Asthma

☐ High/Low Blood Pressure ☐ Tuberculosis ☐ Kidney Disease ☐ Hepatitis ☐ Alcoholism

☐ Blood Transfusion ☐ Diabetes ☐ Neurologica Condition ☐ Epilepsy/Fainting Spells

☐ Emotional Condition ☐ Arthritis ☐ Aids/HIV ☐ Headaches ☐ Abnormal Bleeding

☐ Allergies ☐ Heart Condition/Defect/Angina ☐ Pregnant/Nursing

Allergic to the following? ☐ Latex ☐ Penicillin/antibiotics ☐ Narcotics ☐ Ibuprofen ☐ Sulfa

☐ Other: ______________________________________

Primary Physician______________________ Phone ______________

List current medications ______________________________________

____

Any hospitalization/surgeries in past year? ______________________

____

Doctor's Notes: ______________________________________

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DENTAL HISTORY

Previous Dentist______________________

Phone # ______________________

Date of last exam/cleaning ______________

Question	
Did you have X-rays sent over?	Yes ☐ No ☐
Anxious about dental treatment?	Yes ☐ No ☐
Do you require pre-med?	Yes ☐ No ☐
Satisified with appearance of teeth?	Yes ☐ No ☐
History of Periodontal Disease	Yes ☐ No ☐
Do you clench or grind your teeth?	Yes ☐ No ☐
Do you get cold sores?	Yes ☐ No ☐
Do you smoke or chew tobacco?	Yes ☐ No ☐
Any bad reactions to local anesthetic?	Yes ☐ No ☐
Any sinus trouble?	Yes ☐ No ☐

How often do you brush? ______________

How often do you floss? ______________

Any areas in your mouth bothering you today? _____

____

HOLISTIC HEALTH

Name of Naturopathic Doctor ______________________ Phone #______________ Location ______________

Sensitivities to any of the following? ☐ Fluoride ☐ Gluten ☐ Preservatives ☐ Dyes ☐ Monomers ☐ Mercury ☐ Other ______________

Are you currently... ☐ Oil Pulling ☐ Detoxing ☐ Chelating ☐ Avoiding Fluoride ☐ Metal Sensitive ☐ MTHFR positive

Have you been tested for toxin levels or mercury levels recently? Yes ☐ No ☐ Explain: ______________________

Are you interested in safe mercury removal? Yes ☐ No ☐ Explain: ______________________

Are you taking natural supplements? Yes ☐ No ☐ List: ______________________

____

Do you have any special requests? Yes ☐ No ☐ List: ______________________

____

Rate on the scale how holistic you consider yourself to be? *(with 10 being the most)* 0 1 2 3 4 5 6 7 8 9 10

Signature of Patient *(or guardian)* ______________________________

Date ______________________________

Office Use Only: ______________________

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PLEASE TURN PAGE OVER