NEW HORIZONS DENTAL
General and Cosmetic Dentistry

Patient Information

Name: _____ Today's Date: _____
First Middle Last Preferred Name
Address: _____
Street City State Zip code
Gender: Female / Male Family Status: Single / Married / Widowed Spouse or Parent Name:_____
Social Security #: _____ Date of Birth: _____
Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____
Email Address: _____
Preferred appointment time: □ Morning □ Afternoon □ Evening □ Any time □M □T □W □T □F
In Case of Emergency Who Should We Contact? _____ Relationship _____
Contact Number: _____

Dental History

Name of Last General Dentist: _____
Address: _____ City: _____ State: _____ Zip: _____
Have You Requested for Your Records to be Transferred to Us? Yes / No
If No, Would You Like Us to Request Your Records for You? Yes / No

Date of Last Dental Visit: _____ Reason for this visit: _____
When Was Your Last Dental Cleaning? _____ When Were Your Last Dental X-Rays Done? _____
Do You Floss Your Teeth? Yes / No If yes, How Often: _____
What Kind of Toothbrush Do You Use: Manual / Electric / Both If Electric, What Kind or Model Is It: _____
Have You Ever Had Complications Following Dental Treatment? Yes / No If Yes, Please Describe:_____
_____
Have You Been Advised To Take Antibiotics Prior To Dental Treatment? Yes / No If Yes, Reason: _____
If Yes, What Do You Take: _____
Have You Ever had A Complication or A Reaction To Dental Anesthetics? Yes / No Please Describe: _____
_____

Orthodontics:
Have You Ever Been To An Orthodontist? Yes / No
Have You Ever Had Orthodontic Treatment? Yes / No If Yes, When Did You Have Treatment _____
What Type of Treatment Did You Have? Full Braces / Partial Braces / Retainer Only / Other:_____
Are You Under The Care of An Orthodontist Now? Yes / No
Orthodontist's Name:_____ City:_____ State:_____ Zip:_____

Periodontics:
Have You Ever Been To A Periodontist? Yes / No
Have You Ever Had Periodontal Treatment? Yes / No If Yes, When Did You Have Treatment _____
What Type of Treatment Did You Have?_____
Are You Under Their Care Now? Yes / No If Yes, What Type: _____
Periodontist's Name:_____ City:_____ State:_____
Zip:_____

TMJ – Jaw Joints:
Do Your Jaws (TMJ) Pop, Click or Lock? _____ If Yes, Which Side (s) and How Often:_____
_____
Do You Have Pain When Your Jaws Pop, Click or Lock? Yes / No Which Side(s)? Right / Left
Do You Currently Wear A Removable Acylic Appliance? Yes / No

Pain:
Do you Have Dental Pain or Discomfort Other Than TMJ Now? Yes / No If Yes, Please Describe:_____

Referral Information

Who may we thank for referring you to our practice? □ Another Patient, Friend □ Another Patient Relative
□ Dental Office □ Internet □ School □ Work □ Other _____

Name of person or office referring you to our practice: _____