



# New Patient Information

Montpelier Family Dentistry  
David Koilpillai, DDS

Welcome to our practice.

Please take your time to fill out this form completely. The more we learn about you, the better care we are able to provide. We look forward to working with you to maintain a healthy, happy smile.

## Patient Information

Patient Number \_\_\_\_\_

Today's date \_\_\_\_\_

First name \_\_\_\_\_ Middle initial \_\_\_\_\_ Last name \_\_\_\_\_

I prefer to be called (nickname, etc.) \_\_\_\_\_  Male  Female

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Date of birth \_\_\_\_\_ Social security no. \_\_\_\_\_

Home phone ( ) - \_\_\_\_\_ Work phone ( ) - \_\_\_\_\_ Cell phone ( ) - \_\_\_\_\_

Primary contact number (please check one)  Home  Work  Cell Best time to call \_\_\_\_\_

Fax ( ) - \_\_\_\_\_ E-mail \_\_\_\_\_ Driver's license no. \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Spouse's name \_\_\_\_\_ Spouse's employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

### If the patient is a child

School \_\_\_\_\_ School phone ( ) - \_\_\_\_\_ Grade \_\_\_\_\_

## Dental History

Reason for today's visit \_\_\_\_\_

Are you currently in pain?  Yes  No  
If so, please describe: \_\_\_\_\_

Do you have any dental problems now?  Yes  No  
If so, please describe: \_\_\_\_\_

Have you ever had trouble with a previous dental treatment?  Yes  No  
If so, please describe: \_\_\_\_\_

Level of anxiety about seeing the dentist: \_\_\_\_\_ (least) 1 2 3 4 5 (most)

Date of last dental exam \_\_\_\_\_ Date of last cleaning \_\_\_\_\_ Date of last full mouth X-rays \_\_\_\_\_

Procedure(s) done at last dental visit \_\_\_\_\_

Previous dentist's name \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Phone ( ) - \_\_\_\_\_

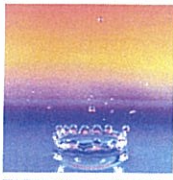
Why are you changing dentists? \_\_\_\_\_

How often do you have dental examinations? \_\_\_\_\_ How often do you brush your teeth? \_\_\_\_\_

How often do you floss? \_\_\_\_\_ What type of bristles do you use?  Hard  Medium  Soft

What other dental aids do you use? (Electric toothbrush, toothpick, etc.) \_\_\_\_\_

Do you require antibiotics before dental treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have frequent headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do your gums ever bleed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you clench or grind your teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you noticed any mouth odors or bad tastes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are your teeth sensitive to heat/cold?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you bite your lips or cheeks frequently?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you still have your wisdom teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No



Have you ever had:

- Periodontal disease/gum treatment
Orthodontics treatment
Oral surgery
A bite plate or mouth guard
Discomfort in your jaw joint (TMJ/TMD)
Your teeth ground or bite adjusted
Serious injury to the mouth or head

If yes to any of the previous questions, please describe

Is there anything else about your past dental treatment(s) that you would like us to know?

Medical History

Have you been hospitalized or under the care of a medical doctor during the past 2 years?

If yes, for what?

Hospital or Physician's name Phone

Hospital or Physician's City State

Have you taken any medications or drugs in the past two years?

Are you currently taking any medications or drugs? (including regular doses of aspirin or over-the-counter medicines)

If yes, please explain

Have you ever taken Fen-Phen?

If so, how long ago?

Have you been to the doctor to check for heart problems?

If so, what are the problems?

Do you use tobacco? Do you use alcohol or any other controlled substance?

Women only:

Are you pregnant or think you may be pregnant? Are you nursing?

Are you taking birth control pills?

Indicate which of the following you have had or have at present:

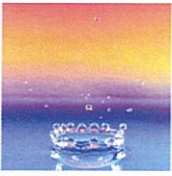
- AIDS/HIV, Alcohol/Drug Abuse, Allergies or Hives, Anemia, Arthritis/Rheumatism, Artificial Heart Valve, Artificial Bones/Joints, Asthma, Blood Disease, Blood Transfusion, Bruise Easily, Cancer/Chemotherapy, Chest Pain, Cold Sores/Herpes, Colitis, Contact Lenses, Cortisone Medicine, Diabetes, Diet (Special/Restricted), Difficulty Breathing, Emphysema, Epilepsy or Seizures, Fainting or Dizzy Spells, Frequent Headaches, Glaucoma, Hay Fever, Heart (Surgery, Disease, Attack), Heart Pacemaker, Heart Murmur, Hemophilia/Abnormal Bleeding, Hepatitis A B C (circle), High or Low Blood Pressure, Hospitalized for Any Reason, Jaundice, Kidney Trouble, Liver Disease, Lupus, Mitral Valve Prolapse, Nervousness/Anxiety, Neurological Disorders, Psychiatric/Psychological Care, Radiation Therapy, Rheumatic/Scarlet Fever, Shingles/Chicken Pox, Sickle Cell Disease/Traits, Sinus Trouble, Snoring/Sleep Apnea, Stomach Problems/ Ulcers, Stroke, Swollen Ankles, Thyroid Problems, Tuberculosis (TB), Tumors, Venereal Disease/STD

Please list any serious medical condition(s) that you have ever had not listed above:

Are you aware of having an allergic (or adverse) reaction to any of the following:

- Aspirin, Codeine, Anesthetics (i.e. Novocaine), Erythromycin, Iodine, Jewelry/Metals, Latex, Penicillin or Other Antibiotics, Sedatives, Sulfa Drugs, Tetracycline, Other

Patient signature



# New Patient Information

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## Dental Insurance

### Primary Carrier

Insurance co. name \_\_\_\_\_ Insurance co. phone \_\_\_\_\_  
 Address (Street, City, State, ZIP) \_\_\_\_\_  
 Group no. (Plan or Policy no.) \_\_\_\_\_ Insured's I.D. no. \_\_\_\_\_  
 Insured's name \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
 Date of birth \_\_\_\_\_ Insured's social security no. \_\_\_\_\_  
 Insured's employer name \_\_\_\_\_ Is insured a patient in our practice?  Yes  No

### Secondary Carrier

Insurance co. name \_\_\_\_\_ Insurance co. phone \_\_\_\_\_  
 Address (Street, City, State, ZIP) \_\_\_\_\_  
 Group no. (Plan or Policy no.) \_\_\_\_\_ Insured's I.D. no. \_\_\_\_\_  
 Insured's name \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
 Date of birth \_\_\_\_\_ Insured's social security no. \_\_\_\_\_  
 Insured's employer name \_\_\_\_\_ Is insured a patient in our practice?  Yes  No

### Person Financially Responsible for Account

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
 Social security no. \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 Driver's license no. \_\_\_\_\_ Date of birth \_\_\_\_\_  
 Address (Street, City, State, ZIP) \_\_\_\_\_  
 Employer \_\_\_\_\_ Work phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 Preferred payment method:  Cash  Credit Card  Check  
 Visa/MC/AMEX no. \_\_\_\_\_ Exp. date \_\_\_\_\_  
 If patient is a minor, name of parent or legal guardian and relationship \_\_\_\_\_  
 Is this parent or legal guardian currently a patient in our office?  Yes  No

### Payment is due in full at the time of treatment

(Unless prior arrangements have been approved)

*I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.*

*I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective healthcare provider or agency that may release such information to you. I will notify the dentist of any changes in my health or medication.*

Signature \_\_\_\_\_ Date \_\_\_\_\_

### Person to contact in case of emergency

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Cell phone \_\_\_\_\_  
 Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

### OFFICE USE ONLY

I VERBALLY REVIEWED THE MEDICAL / DENTAL INFORMATION ABOVE WITH THE PATIENT NAMED HEREIN.

Date \_\_\_\_\_ Initials \_\_\_\_\_



# Smile Analysis

Montpelier Family Dentistry  
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Today's date \_\_\_\_\_

Patient Number \_\_\_\_\_

1. Do you love the way your smile looks?  Yes  No
2. Do you feel comfortable showing your teeth when you laugh or smile?  Yes  No
3. If you could change anything about your smile, it would be (check all that apply):
 

<input type="checkbox"/> Color of your teeth	<input type="checkbox"/> Too much or too little of teeth show when you smile	<input type="checkbox"/> Gaps between your teeth
<input type="checkbox"/> Size/Shape of your teeth	<input type="checkbox"/> Too much or too little of gum shows when you smile	<input type="checkbox"/> Alignment of your teeth
<input type="checkbox"/> Other: _____		
4. Do you have (check all that apply):
 

<input type="checkbox"/> Sensitive or receding gums	<input type="checkbox"/> Worn/broken/chipped teeth	<input type="checkbox"/> Old or discolored fillings	<input type="checkbox"/> Missing teeth
<input type="checkbox"/> Old crowns that have dark edges at the top			
<input type="checkbox"/> Other: _____			
5. In your line of work or lifestyle, do you (check all that apply):
 

<input type="checkbox"/> Visit businesses or clients	<input type="checkbox"/> Travel	<input type="checkbox"/> Speak publicly	<input type="checkbox"/> Other: _____
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6. If you had a smile makeover do you think you'd feel (check all that apply):
 

<input type="checkbox"/> More confident	<input type="checkbox"/> More optimistic	<input type="checkbox"/> Healthier
<input type="checkbox"/> Just OK	<input type="checkbox"/> No different	<input type="checkbox"/> Other: _____
7. Do you or someone in your family have issues with any of the following (check all that apply):
 

<input type="checkbox"/> Chronic bad breath	<input type="checkbox"/> Grinding teeth	<input type="checkbox"/> Snoring
<input type="checkbox"/> Other: _____		

*We'd like to know more about you so we can better serve you!*

8. Do you prefer appointments in the (check all that apply):
 

<input type="checkbox"/> Early morning	<input type="checkbox"/> Early afternoon	<input type="checkbox"/> No preference
<input type="checkbox"/> Late morning	<input type="checkbox"/> Late afternoon	<input type="checkbox"/> Other: _____
9. Do you have any special dates or upcoming events you'd like us to remember? (weddings, graduations, etc.)
   
\_\_\_\_\_
   
\_\_\_\_\_
   
\_\_\_\_\_
10. What type(s) of music do you enjoy? (check all that apply)
 

<input type="checkbox"/> Easy Listening	<input type="checkbox"/> Classical	<input type="checkbox"/> Rock	<input type="checkbox"/> Hip-Hop/Rap
<input type="checkbox"/> Jazz	<input type="checkbox"/> Country	<input type="checkbox"/> R&B	<input type="checkbox"/> Other: _____
11. What are your favorite hobbies or activities?
   
\_\_\_\_\_
   
\_\_\_\_\_
   
\_\_\_\_\_
12. Do you have children and grandchildren? If so, please list their names and ages.
   
\_\_\_\_\_
   
\_\_\_\_\_
   
\_\_\_\_\_
13. Is there anything else that you want our office to know about you that will help us to serve you better?
   
\_\_\_\_\_
   
\_\_\_\_\_
   
\_\_\_\_\_