DR. MINDY'S
FAMILY DENTISTRY

New Patient Form

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

Date: _____ Social Security #: _____ Birthdate: _____

Name: _____ Home Phone: _____
(Last Name, First Name, Middle Initial)

Address: _____ Cell Phone: _____

City: _____ State: _____ Zip: _____ Email: _____

Sex: ☐ M ☐ F ☐ Other _____ Relationship: ☐ Minor ☐ Single ☐ Married ☐ Other _____

Employer: _____ Business Phone: _____

Business Address: _____ Occupation: _____

In case of emergency, who should we contact:

Name: _____ Phone: _____ Relationship: _____
(Last Name, First Name)

Referred by: _____

Primary Insurance

Person Responsible for Account: _____
(Last Name, First Name, Middle Initial)

Relationship to Patient: _____ Birthdate: _____ Social Security #: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____

Responsible Party Employed By: _____ Business Phone: _____

Business Address: _____ Occupation: _____

Insurance Company: _____

Insurance Company Address: _____

Subscriber I.D. #: _____ Group #: _____

Additional Insurance

Insured name: _____
(Last Name, First Name, Middle Initial)

Relationship to Patient: _____ Birthdate: _____ Social Security #: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____

Insured Party Employed By: _____ Business Phone: _____

Insurance Company: _____

Insurance Company Address: _____

Subscriber I.D. #: _____ Group #: _____

Dental History

Former Dentist: _____ City: _____ State: _____

Date of Last X-Rays: _____ Date of Last Dental Visit: _____

How Often Do You Floss: _____ How Often Do You Brush: _____

Please Check All That Apply:

Bad Breath	☐	Loose Teeth or Broken Fillings	☐	Sensitivity to Sweets	☐		
Bleeding Gums	☐	Orthodontic Treatment	☐	Sensitivity When Biting	☐		
Blisters on Lips or Mouth	☐	Pain Around Ear	☐	Frequent Headaches	☐		
Finger Nail Biting	☐	Periodontal Treatment	☐	Jaw, Head or Neck Injuries	☐		
Grinding Teeth	☐	Sensitivity to Cold	☐	Jaw Difficulty: Clicking and/or Pain	☐		
Lip or Cheek Biting	☐	Sensitivity to Heat	☐	Tooth Pain	☐		

Medical History

Physician's Name: _____ Date of Last Visit: _____

	Yes	No
1. Are you currently under medical treatment?	☐	☐
2. Have you ever had any serious illness or operations?	☐	☐
3. Are you currently taking any medication? If yes please list:	☐	☐
_____		
_____		
_____		
_____		
4. Do you smoke?	☐	☐
5. Do you use alcohol, cocaine or other drugs?	☐	☐
6. Do you wear contact lenses?	☐	☐

7. Have you had any allergic reactions to the following:	Yes	No
Local Anesthetics (eg. novacaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates (sleeping pills)	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other	☐	☐

8. (Women Only) Are You:		
Pregnant	☐	☐
Nursing	☐	☐
Taking Birth Control Pills	☐	☐

Please Check All That Apply:

AIDS	☐	Emphysema	☐	Pacemaker	☐
Anemia	☐	Epilepsy	☐	Psychiatric Care	☐
Arthritis, Rheumatism	☐	Fainting or Dizziness	☐	Radiation Treatment	☐
Artificial Heart Valves	☐	Glaucoma	☐	Respiratory Disease	☐
Artificial Joints	☐	Headaches	☐	Rheumatic Fever	☐
Asthma	☐	Heart Murmur	☐	Scarlet Fever	☐
Back Problems	☐	Heart Problems	☐	Shortness of Breath	☐
Bleeding abnormally with extractions or surgery	☐	Hepatitis-Type _____ Herpes	☐	Sinus Problems	☐
			☐	Skin Rash	☐
Blood Disease	☐	High Blood Pressure	☐	Stroke	☐
Cancer	☐	HIV Positive	☐	Swelling of Feet/Ankles	☐
Chemical Dependency	☐	Jaundice	☐	Swollen Neck Glands	☐
Chemotherapy	☐	Jaw Pain	☐	Thyroid Problems	☐
Chronic Fatigue Syndrome	☐	Kidney Disease	☐	Tonsillitis	☐
Circulatory Problems	☐	Latex Sensitivity	☐	Tuberculosis	☐
Congenital Heart Lesions	☐	Liver Disease	☐	Tumor or growth on head/neck	☐
Cortisone Treatments	☐	Low Blood Pressure	☐	Ulcer	☐
Cough-Persistent or Bloody	☐	Mitral Valve Prolapse	☐	Venereal Disease	☐
Diabetes	☐	Nervous Problems	☐		

Assignment and Release

I hereby authorize payment directly to Mindy Fugett, DMD for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party: _____ Date: _____

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4101 Caughlin Square, Suite 4, Reno, NV 89519 | 775.826.5353 | mindysdentistry.com