SANDIA VIEW
FAMILY DENTAL

701 Broadmoor Blvd NE
Rio Rancho, NM 87124
505-891-1100
office@sandiaviewdental.com

NEW PATIENT FORM

Name: _____ Date of Birth: _____

Preferred Name: _____ Gender: _____

Social Security Number: _____ Marital Status: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Mobile Phone #: _____

Email: _____

How did you hear about us?: _____

Employer: _____ Occupation: _____

Preferred Pharmacy: _____

Major Cross Streets: _____

EMERGENCY CONTACT INFORMATION

Name: _____

Phone #: _____ Relationship: _____

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DENTAL INSURANCE

Do you have Dental Insurance?: YES ☐ NO ☐

Dental Insurance Company Name : _____

Policy Holder Name: _____

Policy Holder Date of Birth: _____ Subscriber ID/SSN: _____

Policy Holder Employer: _____

Patient Relationship to Policy Holder: _____

Claims Address (back of card): _____

Group #: _____ Phone #: _____

Do you have Secondary Dental Insurance: YES ☐ NO ☐

Dental Insurance Company Name : _____

Policy Holder Name: _____

Policy Holder Date of Birth: _____ Subscriber ID/SSN: _____

Policy Holder Employer: _____

Policy Holder Address (if not same as patient): _____

Patient Relationship to Policy Holder: _____

Claims Address (back of card): _____

Group #: _____ Phone #: _____

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HEALTH HISTORY

Patient name(Please PRINT): _____ DOB:_____

Are you currently under the care of a physician? _____ Date of last exam: _____

Name of physician: _____ Phone: _____

GENERAL HEALTH INFORMATION

Are you currently being treated for an injury or illness?	Y	N
Have you ever been hospitalized for a serious injury or illness?	Y	N
Are you pregnant or planning to become pregnant in the near future?	Y	N
Are you currently breastfeeding?	Y	N
Are you required to pre-med with antibiotics before dental treatment?	Y	N
Do you use alcohol?	Y	N
Do you use or have you ever used tobacco?	Y	N
Have you ever had an allergic reaction?	Y	N

If you answered yes to any of the questions above, please explain: _____

_____

_____

MEDICATIONS – Please check all medications you are currently taking

Are you taking any pain medications?	Y	N
Are you taking any Antidepressants or Anxiety medications?	Y	N
Are you taking any Diabetes, Cholesterol, or Blood Pressure medications?	Y	N
Are you taking any Allergy or Asthma medications?	Y	N
Are you taking any antibiotics?	Y	N
Are you currently taking any other medications or supplements?	Y	N
Have you ever had an allergic reaction?	Y	N

****A space to list all current medications is provided on the next page*

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MEDICAL CONDITIONS

Do you have a history or are currently being treated for any digestive conditions?	Y	N
Do you have a history or are currently being treated for any Heart or Circulatory conditions?	Y	N
Do you have a history, or are you currently being treated for any Neurological conditions?	Y	N
Do you have a history or are you currently being treated for any Lung or Breathing conditions?	Y	N
Do you have a history or are you currently being treated for any Autoimmune conditions?	Y	N
Head or neck injuries?	Y	N
High Cholesterol?	Y	N
Artificial Joint?	Y	N
History of Cancer	Y	N
Tumor or abnormal growth?	Y	N
Radiation Therapy?	Y	N
Chemotherapy?	Y	N
HIV/AIDS?	Y	N
Diabetes? Type I or Type II (please circle)	Y	N
Anemia?	Y	N
Kidney Disease?	Y	N
Liver Disease?	Y	N
Thyroid Disease?	Y	N
Tuberculosis/Measles/Chicken Pox?	Y	N

Please list all medications you are currently taking: _____

_____

_____

Please list any known allergies, medical conditions, or additional health information not previously documented in your medical history:

_____

_____

_____

Patient Name: _____ Date: _____

Patient/Guardian Signature: _____ Date: _____

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DENTAL HISTORY

Name of previous Dentist: _____

Date of last exam: _____ Date of last cleaning: _____ Type of cleaning: _____

Do you have immediate concerns you would like to address? _____

_____

Personal History

Are you concerned about the appearance of your teeth?	Y	N
Are you interested in improving your smile?	Y	N
Have you had any cavities within the past two years?	Y	N
Are you currently sensitive to biting, sweets, hot or cold?	Y	N
Do you avoid or have difficulty chewing or biting heavily into any hard foods?	Y	N
Do you wake up with a headache or with sore and sensitive teeth? Do you have problems sleeping?	Y	N
Do you wear, or have you ever worn a bite appliance? Either for clenching at night or sleep apnea?	Y	N
Do you bite your nails, chew gum or on pens, hold nails with your teeth or any other oral habits?	Y	N
Does the amount of saliva in your mouth seem too little or do you find yourself with a dry mouth often?	Y	N
Have you ever noticed a consistently unpleasant taste or odor in your mouth?	Y	N

Dental Structural History

Do your gums bleed when brushing or flossing?	Y	N
Is brushing or flossing typically painful?	Y	N
Have you ever experienced or been told you have gum recessions?	Y	N
Have you even been treated for or been told you have gum disease?	Y	N
Have you had any teeth removed for braces or otherwise?	Y	N
Do you know of any missing teeth or teeth that have never developed?	Y	N
Have you ever had braces, orthodontic treatment or spacers, or had a “bite adjustment”	Y	N
Are your teeth becoming more crowded, overlapped, or “crooked”?	Y	N
Are your teeth developing spaces?	Y	N
Do you frequently get food caught between any teeth?	Y	N
Have you noticed your teeth becoming shorter, thinner, or flatter over the years?	Y	N
Do you have problems with your jaw joint? (TMD, popping, clicking, deviating from side to side when opening or closing	Y	N
Is it difficult to open wide?	Y	N
Do you have more than one bite? Or do you notice you shift your jaw around to make your teeth fit together?	Y	N

Patient Name: _____ Date: _____

Patient/Guardian Signature: _____ Date: _____

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Acknowledgment of Receipt of Notice of Privacy Practices

I, the undersigned, acknowledge that I have received, read, and understand the Notice of Privacy Practices provided by Sandia View Family Dental. I understand that this notice describes how my medical information may be used and disclosed, and how I can access this information.

Patient Name (Printed): _____

Patient Signature: _____

Date: _____

Acknowledgment of Financial/Office Policy

I, the undersigned, acknowledge that I have received, read, and understand the Financial Policy of Sandia View Family Dental. I understand my financial responsibilities regarding services rendered by this practice, including payment for services, insurance billing procedures, and any applicable fees.

Patient Name (Printed): _____

Patient Signature: _____

Date: _____

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ELECTRONIC CONSENT FORM

This form is used to obtain your consent to communicate with you by mobile text messaging and email regarding your Protected Health Information.

Sandia View Family Dental offers patients the opportunity to communicate by mobile text messaging. Transmitting patient information by mobile text messaging has a number of risks that patients should consider before granting consent to use mobile text messaging for these purposes. Sandia View Family Dental will use reasonable means to protect the security and confidentiality of mobile text messaging information sent and received. However, Sandia View Family Dental cannot guarantee the security and confidentiality of mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

By signing below, I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of mobile text messaging between Sandia View Family Dental and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Sandia View Family Dental.

Patient Name (Printed): _____

Patient Signature: _____

Date: _____