Hiple Family Dentistry
630 3rd Avenue SW Ste 150
Carmel, Indiana 46032

Adult New Patient Form

Date:_______________

First Name ______________________________ Last Name __________________________________ (Preferred) ____________________

Date of Birth _______________ Age ______ ☐ Male ☐ Female

Address ____ Zip ____________________________

Home # _______________________________ Work # __________________________________ Cell # _________________________________

E-Mail ____ Social Security # __________ - _____ - __________

☐Married ☐Single ☐Widowed (If married) Spouses Name ____

In case of Emergency who should be contacted? __________________________________ Phone # ______________________________________

Employer ____ Occupation ____

Insurance Information

Primary

Name of insured ____ ID # ____
Subscriber SS# ____________________________ Group # ____
Insurance Company ____ Phone # ____
Employer ____

Appointment Information

Which method would you prefer for having your appointment confirmed? You may select as many as you would like.

☐Email ☐Text to cell ☐Home or mobile phone call ☐ All

Dental History

What is the primary reason for today's visit? ☐Cleaning ☐Trauma/Dental Emergency
How often do you… Brush _________ Floss _________
Previous Dentist __________________________________ Last Exam Date _________________ Last X-rays Taken _______________
Any previous dental injuries? ☐ Yes ☐No
Do you wear partials or dentures? ☐Yes ☐No
Are you happy with your smile? ☐Yes ☐No
Are you having any specific problems with your teeth, gums, or mouth at this time? ____
Have you had serious trouble with any previous dental treatment? ____

Nutrition

Drinks (check all that apply)
☐Water ☐Juice ☐Milk ☐Alcohol ☐Gatorade/Sport Drinks ☐Soda

Medical History

Primary Care Physician ____ **Phone** ___________________________

Are you currently under the care of your physician? If yes, why? ____

History of Hospitalizations/ Operations/ Recent Illnesses ____

Current Medications ____

Are you allergic to or have you reacted adversely to any of the following:

- ☐ Local Anesthetic
- ☐ Sulfa Drugs
- ☐ Metals
- ☐ Aspirin
- ☐ Iodine
- ☐ Penicillin
- ☐ Codeine
- ☐ Sedatives / Sleeping Pills
- ☐ Latex
- ☐ Other ________________

Food Allergies ________________________________

Nut Allergies ________________________________

(Check all that apply)

- ☐ Anemia
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Breathing Problems
- ☐ Cancer / Tumor
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Congenital Heart Disorder
- ☐ Cold sores / Fever Blisters
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Diabetes
- ☐ Epilepsy / Seizures
- ☐ Fainting / Dizziness
- ☐ Glaucoma
- ☐ Headaches / Migraines
- ☐ Heart Murmur
- ☐ Heart Trouble / Disease
- ☐ Hemophilia
- ☐ Heart Attack / Failure
- ☐ Hepatitis A B C
- ☐ Herpes
- ☐ High or Low Blood Pressure
- ☐ HIV / AIDS
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ PRE-MED
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Shortness of Breath
- ☐ Skin Rashes / Hives
- ☐ Smoker
- ☐ Smokeless Tobacco User
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcer / Stomach Problems
- ☐ Venereal Disease
- ☐ Other ______________ ____________________

(Women)

Are you pregnant? ☐ yes ☐ no If yes, what is your due date? _________________ Are you currently nursing? ☐ yes ☐ no

Are you on birth control or fertility drugs? ☐ yes ☐ no If yes, please list ____

How did you hear about our office? ____

Do any of your family members come here? ____

CONSENT

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have a change in my health or my medicines I will inform the office at my next appointment without fail.

Our office policy is that patients with insurance pay their deductible as well as the percentage not paid by their policy at the time services are rendered. This signature on file is my authorization for the release of all information necessary to process my claim. I hereby authorize payment directly to the dentist of the insurance benefits otherwise payable to me for services rendered.

Payment is due in full at the time services are rendered. I understand that I am ultimately financially responsible for all charges incurred including all fees associated with the collection of any delinquent balances on my account.

____ ____________

Signature of Patient **Date**