



1201 S Elk Street  
Casper, WY 82601  
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**NEW PATIENT PAPERWORK**

**Today's Date:** \_\_\_\_\_

**Patient Information:**

Full Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Date of Birth (MM/DD/YYYY): \_\_\_\_\_ Gender:  Male  Female  Other \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Married  Divorced  Single  Minor  Separated  Widowed

**Phone Numbers:**

Phone Number (Home): \_\_\_\_\_ Phone Number (Cell): \_\_\_\_\_

Preferred Contact Method:  Phone  Email  Text Email Address (required): \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Emergency Contact Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

**Employer:**

Employer Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

**Dental Insurance Information:**

Primary Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Group Number: \_\_\_\_\_ Employer: \_\_\_\_\_

Subscriber's Name (if different): \_\_\_\_\_ Subscriber's Date of Birth: \_\_\_\_\_

Subscribers SSN: \_\_\_\_\_ Relationship to Patient:  Self  Spouse  Parent  Other

Secondary Insurance Provider (if applicable): \_\_\_\_\_ Policy Number: \_\_\_\_\_

**Medical History:**

Do you have or have you ever had any of the following? (Check all that apply)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> AIDS/HIV                | <input type="checkbox"/> Emphysema          | <input type="checkbox"/> Pacemaker           |
| <input type="checkbox"/> Allergies               | <input type="checkbox"/> Epilepsy/Seizures  | <input type="checkbox"/> Persistent cough    |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Fainting/Dizziness | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Arthritis, Rheumatism   | <input type="checkbox"/> Glaucoma           | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Headaches          | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Joints       | <input type="checkbox"/> Heart Murmur       | <input type="checkbox"/> Sinus Trouble       |

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Heart Problems          | <input type="checkbox"/> Skin Rash           |
| <input type="checkbox"/> Back Problems            | <input type="checkbox"/> Hepatitis (Type: _____) | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Bleeding Disorders       | <input type="checkbox"/> Herpes                  | <input type="checkbox"/> Swollen Neck Glands |
| <input type="checkbox"/> Blood Disease            | <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Thyroid Issues      |
| <input type="checkbox"/> Cancer (Type: _____)     | <input type="checkbox"/> Kidney Disease          | <input type="checkbox"/> Tuberculosis (TB)   |
| <input type="checkbox"/> Chemical Dependency      | <input type="checkbox"/> Liver Disease           | <input type="checkbox"/> Tumor/Head Growth   |
| <input type="checkbox"/> Chemotherapy             | <input type="checkbox"/> Low Blood Pressure      | <input type="checkbox"/> Ulcer               |
| <input type="checkbox"/> Circulatory Problems     | <input type="checkbox"/> Mitral Valve Prolapse   |  |
| <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Mitral Valve Replapse   |  |
| <input type="checkbox"/> Cortisone Treatments     | <input type="checkbox"/> Nervous System Issues   |  |
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Osteoporosis            |  |

**Medications and Allergies:**

Are you taking any medications or supplements?  Yes  No

If yes, please list:

\_\_\_\_\_

\_\_\_\_\_

Do you have any allergies:  Yes  No

Asprin  Local Anesthetic  Penicillin  Codeine  Sulfa  Latex  Other \_\_\_\_\_

\_\_\_\_\_

**Conditions Impacting Dental Health:**

- |   |  |
|---|--|
| <input type="checkbox"/> Acid Reflux/GERD | <input type="checkbox"/> Immunosuppressed Conditions       |
| <input type="checkbox"/> Alcohol Use      | <input type="checkbox"/> Joint Replacement (Date: _____)   |
| <input type="checkbox"/> Blood Thinners   | <input type="checkbox"/> Sinus Problems/Chronic Congestion |
| <input type="checkbox"/> Drug Use         | <input type="checkbox"/> Sleep Apnea (Use CPAP?) Yes No    |
| Type: _____                               | <input type="checkbox"/> Tobacco Use (circle one)          |
| <input type="checkbox"/> Eating Disorders | Vaping, Cigarettes, Pouches, Loose                         |
| Type: _____                               |  |

**Women Only:**

Pregnant (Due Date: \_\_\_\_\_)  Nursing  Taking Birth Control

**Dental History:**

Date of last dental cleaning: \_\_\_\_\_ Reason for today's visit: \_\_\_\_\_

Previous Dentist: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Do you experience any of the following? (Check all that apply)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Bad Breath             | <input type="checkbox"/> Food collection             | <input type="checkbox"/> Ortho treatment       |
| <input type="checkbox"/> Bleeding Gums          | <input type="checkbox"/> Grinding or Clenching Teeth | <input type="checkbox"/> Pain around ear       |
| <input type="checkbox"/> Blisters on lips/mouth | <input type="checkbox"/> Jaw Pain or Clicking (TMJ)  | <input type="checkbox"/> Periodontal treatment |
| <input type="checkbox"/> Broken fills           | <input type="checkbox"/> Loose teeth                 | <input type="checkbox"/> Sensitivity           |

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Burning tongue     | <input type="checkbox"/> Lip/Cheek biting       | <input type="checkbox"/> Sores in Mouth      |
| <input type="checkbox"/> Difficulty Chewing | <input type="checkbox"/> Mouth breathing        | <input type="checkbox"/> Swollen/tender Gums |
| <input type="checkbox"/> Dry Mouth          | <input type="checkbox"/> Mouth Pain w/ Brushing | <input type="checkbox"/> Tooth Pain          |
- 

Have you ever had any of the following procedures? (Check all that apply)

- Fillings  Root Canal  Extractions  Dental Implants  Braces/Invisalign  Dentures/Partials  
 Crowns/Bridges  Gum Surgery

Do you use any dental aids? (Check all that apply)

- Electric Toothbrush  Water Flosser  Nightguard  Retainer

Have you had a bad experience with dental treatment?  Yes  No

If yes, please describe: \_\_\_\_\_

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### **Consent and Acknowledgment**

I hereby authorize Signature Dental to release any medical or dental information necessary to process my claims for payment.

I acknowledge that I am responsible for the payment of all dental services rendered to me, regardless of insurance coverage.

I agree to notify the office of any changes to my medical or insurance status.

Signature of Patient (or Guardian if Minor): \_\_\_\_\_

Date: \_\_\_\_\_