

New Patient Information

About You...

Name (First) (MI) (Last) _____

Mr. Mrs. Ms. Dr. I prefer to be called _____

Birthdate _____ SS# _____

Home Address _____

City, State _____ Zip _____

Single Married Divorced Widowed Separated

Home Phone _____ Mobile/Pager# _____

Work # _____ Ext. _____

Email _____ DL# _____ State _____

Employer _____

Employer's Address _____

How long there _____ Occupation _____

Where and when are the best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us _____

Spouse Information...

His / Her Name _____

Employer _____

Work # _____ Ext. _____

Birthdate _____

Sunlife Dental Group

73-211 Fred Waring Drive
Suite 201
Palm Desert, CA 92260

Phone: (760) 568-3368
Fax: (760) 568-3369

Url: www.sunlifedental.com
E-mail: info@sunlifedental.com

Dental Insurance

Primary Dental Insurance
Name of Insurance Co. _____

Address _____

Phone # _____

Group # (Plan, Local or Policy #) _____

Insured's Name _____

Relation _____

Insured's Birthdate / / Insured's SS# _____

Insured's Employer _____

Secondary Dental Insurance
Name of Insurance Co. _____

Address _____

Phone # _____

Group # (Plan, Local or Policy #) _____

Insured's Name _____

Relation _____

Insured's Birthdate / / Insured's SS# _____

Insured's Employer _____

Emergency Contact

In the event of an emergency, is there a person you would like us to contact?
Name of Contact _____

Relationship _____

Home # _____

Work # _____ Ext. _____

Medical History

Name (First) (MI) (Last)

Are you currently under the care of a physician? Yes No

Do you have a personal physician? Yes No

Physician's name

Your current physical health Excellent Fair Poor

Have you taken the drugs fenfluramine and or phentermine (fen-phen) or (redux)? Yes No

Are you currently taking any prescriptions/over the counter drugs? Yes No

Please List:

FOR WOMEN: Are you taking birth control pills? Yes No

Are you pregnant? Yes - Week# No

Are you nursing? Yes No

Have you had any of the following diseases or medical problems?

Y N	Abnormal Bleeding	Y N	Hepatitis
Y N	Alcohol/ Drug Abuse	Y N	Herpes/ Fever Blisters
Y N	Anemia	Y N	High Blood Pressure
Y N	Arthritis	Y N	HIV+/AIDS
Y N	Artificial Bones/Joints/ Valves	Y N	Hospitalized for Any Reason
Y N	Asthma	Y N	Kidney Problems
Y N	Blood Transfusion	Y N	Liver Disease
Y N	Cancer/ Chemotherapy	Y N	Low Blood Pressure
Y N	Colitis	Y N	Mitral Valve Prolapse
Y N	Congenital Heart Defects	Y N	Pacemaker
Y N	Diabetes	Y N	Psychiatric Problems
Y N	Difficulty Breathing	Y N	Radiation Treatment
Y N	Emphysema	Y N	Rheumatic/ Scarlet Fever
Y N	Epilepsy	Y N	Seizures
Y N	Fainting Spells	Y N	Shingles
Y N	Frequent Headaches	Y N	Sickle Cell Disease
Y N	Glaucoma	Y N	Sinus Problems
Y N	Hay Fever	Y N	Stroke
Y N	Heart Attack	Y N	Thyroid Problems
Y N	Heart Murmur	Y N	Tuberculosis (TB)
Y N	Heart Surgery	Y N	Ulcers
Y N	Hemophilia	Y N	Venereal Disease

For doctor's comments only:

Please list any serious medical condition(s) that you have ever had:

Are you allergic to any of the following?

Y N	Aspirin	Y N	Dental Anesthetics
Y N	Latex	Y N	Tetracycline
Y N	Codeine	Y N	Erythromycin
Y N	Penicillin	Y N	Other

Please list any other drugs that you are allergic to:

Dental History

Why have you come to the dentist today?

Are you currently in pain or discomfort with your teeth and/or gums?

Yes No

How would you describe the condition of you teeth and gums?

Poor Fair Excellent

Previous/Present Dentist

Last visit date

Are you interested in fewer dental appointments Yes No

Y N	Do you feel you are meticulous with your oral hygiene?	Y N	Are you unhappy with any silver or discolored fillings?
Y N	Do you understand the correlation between dental plaque control and the prevention of gum disease?	Y N	Do you have crowns or bridges which are unattractive or unnatural looking?
Y N	Do your gums ever bleed?	Y N	Do you sometimes feel uncomfortable with the appearance of your smile?
Y N	Have you ever been told you have gum disease?	Y N	Are your teeth crooked or crowded?
Y N	Do you grind or clench your teeth?	Y N	Do you have one or more missing teeth?
Y N	Have you ever had pain/discomfort in your jaw joint?	Y N	Do you have unattractive spaces between your teeth?
Y N	Would you like to keep your natural teeth for as long as you live?	Y N	Do you think a more attractive smile would improve your personal and/or professional relationships?
Y N	Do you get frustrated that you need work done everytime you go to the dentist?	Y N	Do you often feel as if your breath is not as fresh as it could be?
Y N	Would you like to have whiter teeth?	Y N	Have you ever been told that you have "bad breath"?
Y N	Would you like your teeth to be straighter?	Y N	

What level of dental care do think your dental insurance company will cover?

Poor Fair Excellent

What level of dental care would you like to have for yourself?

Poor Fair Excellent

I understand that the information that I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature Patient/Guardian Date

Signature Doctor Date