Southern
Family Dental

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Lafayette, LA
Suite 303

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New Patient Form

Patient Information

First Name: _____ Last Name: _____ MI: _____

Address: _____ City: _____ State _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Social Security Number: _____ DOB: _____

Medicaid ID# (13 Digits): _____

If patient is under 18:

Mother's Name: _____ Mother's Phone: _____

Father's Name: _____ Father's Phone: _____

Guardian's Name: _____ Guardian's Phone: _____

Medical History Select all that apply

- ☐ Abnormal Bleeding
- ☐ ADD/ADHD
- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints/Valves
- ☐ Asperger's/Autism
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Crohn's Disease
- ☐ Circulatory Problems
- ☐ Congenital Heart Defects
- ☐ Cough (persistent, bloody)
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Emphysema
- ☐ Epilepsy/Seizure Disorders
- ☐ Gastrointestinal Disorders
- ☐ Glaucoma
- ☐ Headaches/Migraines
- ☐ Heart Murmurs
- ☐ Heart Disease/Pacemaker
- ☐ Hepatitis Type ___
- ☐ Herpes Types ___
- ☐ Jaundice
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental Disabilities
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders/Anxiety
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Skin Rash
- ☐ Special Diet/Restrictions
- ☐ Stroke
- ☐ Swelling (neck glands/ feet/ ankles)
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor or Growth (head/neck)
- ☐ Ulcer
- ☐ Venereal Disease/STD's
- ☐ Weight Loss/Gain

Physician's Name: _____ Physician's Phone: _____

In the space provided below, please provide any additional medical information:

Has the patient been hospitalized within the last five years? ☐

☐ Yes

☐ No

Dental History

Name of Previous Dentist/Dental Clinic: _____

Why are you here to see the dentist today? _____

When was your last dental visit? What was done? _____

IF FEMALE:
Are you pregnant or trying to become pregnant?

☐ Yes

☐ No

If pregnant, what is your due date? _____

If not pregnant, are you taking birth control pills?

☐ Yes

☐ No

PLEASE LIST ANY MEDICATIONS PATIENT IS CURRENTLY TAKING:

_____

PLEASE LIST ANY ALLERGIES TO THE FOLLOWING (check all that apply):

☐ Aspirin ☐ Codeine ☐ Dental Anesthetics ☐ Latex ☐ Metals/Nickel
☐ Penicillin ☐ Sulfa ☐ Erythromycin ☐ Tetracycline

I affirm that the information I have given is correct to the best of my knowledge. The information given will be for use in my (or my child's) treatment, billing and processing of insurance or Medicaid benefits to which I (or my child) am entitled. Information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status (or my child's medical status). I authorize the dental staff to perform the necessary dental services that I (or my child) may need.

Name: _____ Date: _____

Physician's Name: _____ Physician's Phone: _____

In the space provided below, please provide any additional medical information:

Has the patient been hospitalized within the last five years? ☐

☐ Yes

☐ No

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Name: _____ Date: _____