

Dr. Richard Parker :: Dental Design Studio

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Online New Patient Form

Please fill out form completely using Adobe Acrobat Reader 8.0 or later. All red fields are required.

Date: _____

Last Name: _____

First Name: _____

Preferred: _____

Mailing Address: _____

Home Phone: _____

Work Phone: _____

Mobile: _____

E-mail: _____

Date of Birth: _____

Who referred you to us? _____

Are you having any areas of concern?

- I'm in good dental health and don't have any areas of concern
- I think I may have some problems with my gums
- I would like to improve the appearance of my smile
- I'm having problems with { y bite
- It has been a long time since I've been to a dentist
- I could have some decay or a broken filling
- I have pain from a jaw problem and TMJ
- I have old mercury fillings I'd like to have replaced.
- Other _____

How would you describe the present state of the health of your mouth?

- Poor
- Below Average
- Average
- Good
- Excellent

What do you already know about our office & what are your expectations?

Tell us about your previous dental experiences:

Has the cost of dental treatment been a concern for you?

- Yes
- No

What can we do to help you with this?

Has fear ever been an issue for you in a dental office?

- Yes
- No

What caused you to leave your last dental office?

Is time a factor in getting your dental work done?

- Yes
- No

Are there any other issues we need to be aware of prior to our evaluation?

Health and Dental History

Physician's Name

Phone

Are you taking any medication, including dosages of aspirin?

Yes

No

If so, please list name & dosage:

Are you aware of having an allergic reaction to any medication or substance?

Yes

No

If so, please list:

Have you been under the care of a medical doctor during the past two years?

Yes

No

If so, why?

Have you seen an Ear, Nose & Throat Specialist?

Yes

No

Name:

Have you seen a chiropractor?

Yes

No

Name: _____

Have you seen a neurologist?

Yes

No

Name: _____

Have you had braces?

Yes

No

Name: _____

Indicate any of the following you have had, or currently have. Please select yes or no.



.....Yes / No

Yes / No

Heart concerns

Psychiatric/Psychological

Congenital Heart Disease

Headaches

Heart Murmur

Jaw Pain

High Blood Pressure

Jaw Popping

Mitral Valve Prolapse

Limited Jaw Opening

Artificial Heart Valve

Congested Ears

Pacemaker

Dizziness

Stroke

ringing Ears

.....Yes / No



Yes / No

Asthma

Loose Teeth

Liver Disease/Jaundice

Posture Problems

Latex Sensitivity

Clenching

Artificial Joints

Grinding

Breast Implants

Facial Pain

Kidney Trouble

Sensitive Teeth

Radiation/Chemotherapy

Neck Ache

Epilepsy/Seizures

Bell's Palsy

Diabetes

Difficulty Swallowing

Hepatitis

Difficulty Chewing

AIDS/HIV

Trigeminal Neuralgia

Sickle Cell Disease

Tingling in Arms/Fingers

Neurological Disorders

Insomnia

Does floss shred when you use it?

■ Yes

■ No

Do you smoke or chew tobacco?

■ Yes

■ No

Does food pack or catch between your teeth?

Yes

No

Do your gums bleed?

Yes

No

Does your breath concern you?

Yes

No

Are you pregnant?

Yes

No

Nursing?

Yes

No

Taking birth Control?

Yes

No

Signature at Office Visit: _____ Date: _____

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- *Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly*
- *Obtain payment from third-party payers*
- *Conduct normal healthcare operations such as quality assessments and physician certifications*

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature at Office Visit: _____ *Date:* _____

If using an Internet E-mail service such as Hotmail or Yahoo, please save this PDF form and E-mail as an attachment to: beth@richardparkerdds.com.