DRS. HANSEN & TORBA

NEW PATIENT FORM

(Please Print)

Today's date:	Physician Name:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Social Security Number	Email Address	Birth date: / /	Age:	Gender Identity ❑ M ❑ F

Street address:	Mobile phone no.: ( )	Home phone no.: ( )

City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose office because/Referred to office by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Name of Primary insurance

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Drs. Hansen & Torba or insurance company to release any information required to process my claims.

Patient/Guardian signature _____ *Date* _____

(OVER FOR SIDE 2)

Are you currently seeing a physician for treatment of a recent or ongoing medical condition?
☐ Yes
(please explain)_____
☐ No

Have you been hospitalized within the last year?
☐ Yes
(please explain)_____
☐ No

Have you ever had any serious medical trouble associated with any dental experience?
☐ Yes
(please explain)_____
☐ No

Have you ever been advised to take antibiotics (like penicillin, etc.) before a dental appointment?
☐ Yes
(please explain)_____
☐ No

If you have a pacemaker, please list date of placement:

If you are diabetic, please list your type and insulin dosage:

If you have artificial joints, please list which and dates of placement:

Do you consider yourself currently under an abnormally high amount of stress?
☐ Yes
☐ No

Do you now or have you had any of the following cardiovascular diseases?
☐ Heart disease
☐ Hardening of the arteries
☐ Heart attack
☐ High blood pressure
☐ Coronary bypass
☐ Stroke
☐ Angina
☐ Heart murmur
☐ Mitral valve prolapse
☐ Congestive heart failure
☐ Rheumatic fever or rheumatic heart disease
☐ Congenital heart defects
☐ Artificial heart valves
☐ High blood pressure
☐ High cholesterol
☐ Shortness of breath after mild exercise
☐ Shortness of breath when you lie down
☐ Swelling of ankles

If you have hepatitis, please select which type:
☐ Type A
☐ Type B
☐ Type C
☐ Other
☐ Non-specific type
☐ Do not know the type

If your hepatitis has required a blood transfusion, please list the date of that procedure:

Have you:
☐ Had a TB test
☐ Had a cough lasting more than three weeks
☐ Coughed up blood

Check any that apply to you:
☐ Allergies
☐ Glaucoma
☐ Alzheimer's
☐ Anemia
☐ Herpes
☐ Asthma
☐ Arthritis
☐ Autoimmune
☐ Blood Disorder
☐ Cancer
☐ Chemo Therapy
☐ Chronic Sinus
☐ Cirrhosis
☐ Depression
☐ Diabetes
☐ Drug/Alcohol treatment or disorder
☐ Eating Disorder
☐ Epilepsy/Seizures
☐ Jaundice
☐ Kidney Disease
☐ Organ Transplant
☐ Osteoporosis
☐ Parkinson's
☐ Radiation Treatment
☐ Severe Headaches
☐ Sexually Transmitted Disease
☐ Skin Problems
☐ Ulcers
☐ Other

Do you have tuberculosis?
☐ Yes
☐ No

Are you HIV positive?
☐ Yes
☐ No

Do you have reason to suspect you have been exposed to the HIV virus
☐ Yes
☐ No

Have you had an unexplained or unplanned weight loss recently?
☐ Yes
☐ No

Do you drink alcohol?
☐ Yes
☐ No

Do you now or have you ever smoked?
☐ Yes
☐ No

If you currently smoke, how much?

If you were a smoker, when did you quit?

Have you ever taken oral biophosphonates for bone density (Boniva, Fosamax, etc.)?
☐ Yes
☐ No

If you chew tobacco, how much?

Please list all current medications you are taking:

Are you allergic to any of the following (get hives, a rash, have trouble breathing, etc.):
☐ Antibiotics (penicillin, tetracycline)
☐ Local dental anesthetics (novocain)
☐ Latex
☐ Codeine
☐ Aspirin
☐ Barbiturates or Sedatives
☐ Tranquilizers
☐ Others

If you have had an adverse reaction to any drug or medication please list it here:

Do you have any disease, condition or medical problem not listed you feel we should know about?

If you have a denture or partial denture, how old are they?

WOMEN ONLY: If you are currently pregnant, please select your expected delivery date:

How would you assess your general health?
☐ Good
☐ Fair
☐ Poor

WOMEN ONLY: Have you reached menopause?
☐ Yes
☐ No

Are you currently taking a prescribed blood thinning medication?
☐ Yes
☐ No

WOMEN ONLY: Are you on hormone replacement therapy?
☐ Yes
☐ No