



Cleveland Family DENTISTRY

Vic Uhrenholdt DDS, FAGD
Chris Aguirre DDS

New Patient Information

Date: _____

Name: _____ Soc. Sec #: _____

Address: _____ D. L. #: _____

City: _____ State: _____ Zip: _____ E-Mail: _____

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

Sex: M F Age: _____ Birthdate: _____ Minor Single Married

Patient Employer/School: _____ Occupation: _____

Employer Address: _____ Phone #: _____

How would you like our office to confirm your appointments? Phone Text E-mail

In case of emergency, who should be notified? _____ Phone # _____

Referral Information – Whom may we thank for referring you to our practice?

- Patient/Friend Our Staff Yellow Pages Work Our Sign School Work
- Patient/Relative Newsletter Website Facebook Google Other _____

Name of the person or office referring you to our practice: _____

Medical History

Physicians Name: _____ Phone #: _____

Have you had any serious illnesses or operations? Yes No If Yes, Describe: _____

Are you taking any blood thinners? Yes No Please List: _____

Do you have to be pre-medicated before any dental treatments? Yes No Reason: _____

Do you have any other medical problem or medical history NOT on this form? Yes No

Please List: _____

WOMEN ONLY

Are you pregnant? Yes No Are you nursing? Yes No Taking birth control pills? Yes No

Sleep Wellness:

Has anyone ever told you that you snore? Yes No

Do you often feel tired, fatigued, or sleepy during the day? Yes No

Has anyone observed you stop breathing during your sleep? Yes No

Check if you have or have had any of the following:

- Anemia
- Cancer
- Heart Problems
- Mitral Valve Prolapse
- Arthritis
- Chemotherapy
- Hepatitis
- Pacemaker
- Artificial Heart Valve
- Diabetes
- High Blood Pressure
- Respiratory Disease
- Artificial Joints
- Epilepsy
- HIV/AIDS
- Rheumatic Fever
- Asthma
- Fainting
- Jaw / TMJ Pain
- Stroke
- Back Problems
- Headaches
- Liver/Kidney Disease
- Use Tobacco/Smoke

Are you allergic to any of the following?

- Penicillin
- Aspirin
- Local Anesthetics
- Other
- Codeine
- Latex
- Sulfa Drugs
- Other

Please list all medications you are currently taking

Medicine _____ Condition _____

Medicine _____ Condition _____

Medicine _____ Condition _____

Dental History

Reason for today's visit:

Previous Dentist: _____ Last Visit: _____

Reason for changing dentist: _____

Are you nervous about seeing a dentist? Yes No If yes, please tell us why:

Yes	No	Are any of your teeth sensitive?	Yes	No	I have problems eating
Yes	No	I clench/grind my teeth	Yes	No	I have had orthodontics
Yes	No	My gums bleed while brushing/flossing	Yes	No	I like my smile
Yes	No	I have loose teeth or broken fillings	Yes	No	I want my teeth straight
Yes	No	I hear clicking or popping in my jaw	Yes	No	I want my teeth whiter

Responsible Party

Name of insurer: _____ Soc Sec# _____

Relationship to patient: _____ Birthdate: _____

Address (if different from patient): _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Person insured employed by: _____ Occupation:

Insurance Company: _____ Phone

Group #: _____ Subscriber:

Name of other dependents covered under plan:

**We accept Cash, Check, Visa, Mastercard, Discover
Financing available through Care Credit - Ask us how!**

As a courtesy, we are happy to assist you in filing your dental insurance. We are an out of network provider for all insurance companies. We will collect your estimate portion on the day of service and will wait 30 days to obtain the balance from your insurance company. Any portion not paid by your insurance company in 30 days will be collected from the patient. Our doctors will provide dental care based on your needs and will not be based on what your insurance may or may not cover. Our goal is to provide you with exceptional service in obtaining excellent oral health.

The patient or guarantor is responsible for the fee at the time of treatment unless prior arrangements have been approved.

I understand that the fee quoted will be valid for a period of 12 months from the date of the patients examination. I hereby authorize payment to Cleveland Family Dentistry for my insurance benefits. I understand that I'm ultimately responsible for all costs for the dental treatment. I grant the right to Cleveland Family Dentistry to release my dental/medical histories and other information about my dental treatment to third party payers.

Patient Insured

Date