Tel (480) 508-6501
Fax (480) 758-5789

Info@McDowellSmiles.com
McDowellSmiles.com

New Patient Information Form

I would like to take the time and welcome you to our practice. We thrive to provide you with the best quality care, and to do so, we would love to know a little bit more about you. We are here to help, so if you require any assistance, please do not hesitate to ask one of our fantastic patient service representatives.

First Name: ______________________ Date of Birth

Middle Name: ______________________

Last Name: ______________________ Gender Male Female

Mobile Phone Number ______________________

Email Address ____

Home Address ______________________ ______________________

City ______________ State ______________ Zip Code______________

Preferred method of contact Email Text Phone Call

Preffered Language English Farsi Spanish

Dental Insurance Info. If you do not have any, please move on to the next section

Insurance Carrier ____

Subscriber Name ____

Subscriber ID number (we might need your social security information if you do not know the ID number/Card) ____

Group Number: ______________________________

Subscribers Employer if any ____

Emergency Contact

Name ______________________________ Phone Number ______________

Relationship ____

Do you suffer from any of the following conditions?

	Y	N		Y	N
Diabetes			**Bleeding Disorder**		
Heart Condition			**Ulcers**		
High Blood pressure			**Liver Disease**		
Stroke			**Kidney Disease**		
Heart Attach			**Psychiatric Care**		
Heart Murmur			**Asthma**		
Joint replacement			**Sinus Trouble**		
Chronic Headaches					

Please tell us if you are allergic to any of the following

	Y	N		Y	N
Aspirin/Ibuprofen			**Vicodin**		
Amoxicillin/Penicillin			**Clindamycin**		
Epinephrine			**Iodine / shellfish**		
Anesthetic			**Latex**		
Please list any other allergies that are not listed above					

Are you currently or have you ever taken any of the following medications

	Y	N		Y	N
Coumadin \Warfarin			**Bisphosphonate**		
Aspirin			**Actonel**		
Other blood thinners			**Boniva**		
Plavix			**Fosomax**		
Please List any other Medications you are taking now					

____________________________	____________________________	____________________________
____________________________	____________________________	____________________________
____________________________	____________________________	____________________________

What brings you in to our office today?	____
Do you have any pain?	____
If yes how would you describe your pain?	____
Are you happy with your smile?	____
Do you smoke Or Chew Tobacco	____

Are you interested in any of the following? Would you like Dr. Rouhani to discuss these with you?

	Y	N		Y	N
Dental whitening			**In Office Whitening**		
Replacement of missing teeth			**Dental Implants**		
Dentures			**Dentures over implants**		
Orthodontics			**Invisalign / Clear Aligners**		
Cosmetic Dentistry			**Veneers**		

Please verify that all the information that you have given is true to the best of your knowledge and that you have been given the chance to ask for help or to ask any questions.

Name of Person Filling out the form ____

Relationship to the patient ____

Today's Date ________________________________