## New Patient Information

Name:	Date:				
Address:	Name:		FIRST	NICKNAME	
Email: Mobile: Work phone: Work phone: Work phone: Work phone: Work phone: PHONE: PHONE: PHONE: PHONE: Therested in Financing Information?	☐ Married ☐ Sin	gle	☐ Male ☐ Female	Date of Birth:	
Home Phone: Mobile:	Address:		CITY	STATE ZIP	
Occupation:	Email:				
Emergency Contact:    NAME/RELATIONSHIP   PHONE:     Interested in Financing Information?   Yes   No     Are you currently wearing dentures?   Yes   No   If yes, how long?     What brought you in today?     CHECK ALL THAT APPLY:   Radiation (head and neck)     IV Bisphosphonates   Heart attack or valve   Rampant infection	Home Phone:			Mobile:	
Interested in Financing Information?	Occupation:			Work phone:	
Are you currently wearing dentures?	Emergency Contac	ct:	Р	PHONE:	
What brought you in today?  CHECK ALL THAT APPLY:  Active cancer Rx  Pregnancy Radiation (head and neck)  IV Bisphosphonates  Rampant infection	Interested in Finar	ncing Information?	□ Yes □ No		
CHECK ALL THAT APPLY:  Active cancer Rx Pregnancy Radiation (head and neck)  IV Bisphosphonates Heart attack or valve Rampant infection	Are you currently	wearing dentures?	□ Yes □ No	If yes, how long?	
□ Active cancer Rx □ Pregnancy □ Radiation (head and neck) □ IV Bisphosphonates □ Heart attack or valve □ Rampant infection	What brought you	in today?			
☐ IV Bisphosphonates ☐ Heart attack or valve ☐ Rampant infection	CHECK ALL THAT	APPLY:			
☐ Osteoporosis Medications ☐ Uncontrolled diabetes ☐ Fixed implant bridge(s) ☐ Tumor (head and neck) ☐ (A1C above 6.4)	☐ IV Bisphosphon ☐ Osteoporosis Me	ates edications	☐ Heart attack or valve replacement within 6 months	☐ Rampant infection ☐ Uncontrolled diabetes	
I understand that I am responsible for all costs of dental treatment. I hereby authorize Dr Andrew Mancin to administer such medications and perform such diagnostic photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to other health professionals by any method, including electronic transfer. I hereby give my consent for Dr Andrew Mancin to send Text Messages and Email messages to the telephone number and address that I provided.	medications and p The information o dentist to release r any method, inclu- messages to the te	erform such diagnostion this page and the der ny dental/medical histo ding electronic transfe	photographic and therapeutic proce ntal/medical histories are correct to to ories and other information about m r. I hereby give my consent for Dr Ai	edures as may be necessary for proper der he best of my knowledge. I grant the righ y dental treatment to other health profes:	ntal care. nt to the sionals by