New Patient Information

Date: ______________________

Name: ____
LAST FIRST NICKNAME

☐ Married ☐ Single ☐ Male ☐ Female Date of Birth: ______________________

Address: ____
STREET CITY STATE ZIP

Email: ____

Home Phone: ______________________ Mobile: ______________________

Occupation: ______________________ Work phone: ______________________

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? ____

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CHECK ALL THAT APPLY:

☐ Active cancer Rx
☐ IV Bisphosphonates
☐ Osteoporosis Medications
☐ Fixed implant bridge(s)
☐ Pregnancy
☐ Heart attack or valve replacement within 6 months
☐ Tumor (head and neck)
☐ Radiation (head and neck)
☐ Rampant infection
☐ Uncontrolled diabetes (A1C above 6.4)

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.

Signature: ____