New Patient Information

Midnight Sun Dental
Philip Latteier, DDS
Steven Hubacek, DDS

Welcome to our practice.

Please take your time to fill out this form completely. The more we learn about you, the better care we are able to provide. We look forward to working with you to maintain a healthy, happy smile.

Patient Information

Patient Number _____

Today's date _____

First name _____ Middle initial _____ Last name _____

I prefer to be called (nickname, etc.) _____ ☐ Male ☐ Female

Address _____ City _____ State _____ ZIP _____

Date of birth _____ Social security no. _____

Home phone (___) ___ - _____ Work phone (___) ___ - _____ Cell phone (___) ___ - _____

Primary contact number (please check one) ☐ Home ☐ Work ☐ Cell Best time to call _____

Fax (___) ___ - _____ E-mail _____ Driver's license no. _____

Employer _____ Occupation _____

Spouse's name _____ Spouse's employer _____

Whom may we thank for referring you? _____

If the patient is a child

School _____ School phone (___) ___ - _____ Grade _____

Dental History

Reason for today's visit _____

Are you currently in pain? ☐ Yes ☐ No

If so, please describe: _____

Do you have any dental problems now? ☐ Yes ☐ No

If so, please describe: _____

Have you ever had trouble with a previous dental treatment? ☐ Yes ☐ No

If so, please describe: _____

Level of anxiety about seeing the dentist: (least) 1 2 3 4 5 (most)

Date of last dental exam _____ Date of last cleaning _____ Date of last full mouth X-rays _____

Procedure(s) done at last dental visit _____

Previous dentist's name _____

City _____ State _____ Phone (___) ___ - _____

Why are you changing dentists? _____

How often do you have dental examinations? _____ How often do you brush your teeth? _____

How often do you floss? _____ What type of bristles do you use? ☐ Hard ☐ Medium ☐ Soft

What other dental aids do you use? (Electric toothbrush, toothpick, etc.) _____

Do you require antibiotics before dental treatment?	☐ Yes	☐ No	Do you have frequent headaches?	☐ Yes	☐ No
Do your gums ever bleed?	☐ Yes	☐ No	Do you clench or grind your teeth?	☐ Yes	☐ No
Have you noticed any mouth odors or bad tastes?	☐ Yes	☐ No	Are your teeth sensitive to heat/cold?	☐ Yes	☐ No
Do you bite your lips or cheeks frequently?	☐ Yes	☐ No	Do you still have your wisdom teeth?	☐ Yes	☐ No

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Have you ever had:

Periodontal disease/gum treatment	☐ Yes	☐ No	Discomfort in your jaw joint (TMJ/TMD)	☐ Yes	☐ No
Orthodontics treatment	☐ Yes	☐ No	Your teeth ground or bite adjusted	☐ Yes	☐ No
Oral surgery	☐ Yes	☐ No	Serious injury to the mouth or head	☐ Yes	☐ No
A bite plate or mouth guard	☐ Yes	☐ No			

If yes to any of the previous questions, please describe _____

Is there anything else about your past dental treatment(s) that you would like us to know? _____

Medical History

Have you been hospitalized or under the care of a medical doctor during the past 2 years? ☐ Yes ☐ No

If yes, for what? _____

Hospital or Physician's name _____ Phone _____

Hospital or Physician's City _____ State _____

Have you taken any medications or drugs in the past two years? ☐ Yes ☐ No

Are you currently taking any medications or drugs? (including regular doses of aspirin or over-the-counter medicines) ☐ Yes ☐ No

If yes, please explain _____

Have you ever taken Fen-Phen? ☐ Yes ☐ No

If so, how long ago? _____

Have you been to the doctor to check for heart problems? ☐ Yes ☐ No

If so, what are the problems? _____

Do you use tobacco? ☐ Yes ☐ No **Do you use alcohol or any other controlled substance?** ☐ Yes ☐ No

Women only:

Are you pregnant or think you may be pregnant?	☐ Yes	☐ No	Are you nursing?	☐ Yes	☐ No
Are you taking birth control pills?	☐ Yes	☐ No			

Have you ever taken Osteoporosis medication? ☐ Yes ☐ No

If so, how long ago? _____

Indicate which of the following you have had or have at present:

AIDS/HIV	☐ Yes	☐ No	Difficulty Breathing	☐ Yes	☐ No	Lupus	☐ Yes	☐ No
Alcohol/Drug Abuse	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No
Allergies or Hives	☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No	Nervousness/Anxiety	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fainting or Dizzy Spells	☐ Yes	☐ No	Neurological Disorders	☐ Yes	☐ No
Arthritis/Rheumatism	☐ Yes	☐ No	Frequent Headaches	☐ Yes	☐ No	Psychiatric/		
Artificial Heart Valve	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Psychological Care	☐ Yes	☐ No
Artificial Bones/Joints	☐ Yes	☐ No	Hay Fever	☐ Yes	☐ No	Radiation Therapy	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart (Surgery, Disease,			Rheumatic/Scarlet Fever	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Attack)	☐ Yes	☐ No	Shingles/Chicken Pox	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No	Heart Pacemaker	☐ Yes	☐ No	Sickle Cell Disease/Traits	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Cancer/Chemotherapy	☐ Yes	☐ No	Hemophilia/Abnormal			Snoring/Sleep Apnea	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No	Bleeding	☐ Yes	☐ No	Stomach Problems/ Ulcers	☐ Yes	☐ No
Cold Sores/Herpes	☐ Yes	☐ No	Hepatitis A B C (circle)	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Colitis	☐ Yes	☐ No	High or Low Blood Pressure	☐ Yes	☐ No	Swollen Ankles	☐ Yes	☐ No
Contact Lenses	☐ Yes	☐ No	Hospitalized for Any Reason	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Cortisone Medicine	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Tuberculosis (TB)	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Kidney Trouble	☐ Yes	☐ No	Tumors	☐ Yes	☐ No
Diet (Special/Restricted)	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No			

Please list any serious medical condition(s) that you have ever had not listed above:

_____

Are you aware of having an allergic (or adverse) reaction to any of the following:

Aspirin	☐ Yes	☐ No	Iodine	☐ Yes	☐ No	Sedatives	☐ Yes	☐ No
Codeine	☐ Yes	☐ No	Jewelry/Metals	☐ Yes	☐ No	Sulfa Drugs	☐ Yes	☐ No
Anesthetics (i.e. Novocaine)	☐ Yes	☐ No	Latex	☐ Yes	☐ No	Tetracycline	☐ Yes	☐ No
Erythromycin	☐ Yes	☐ No	Penicillin or Other Antibiotics	☐ Yes	☐ No	Other _____		

Patient signature_____

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Dental Insurance

Primary Carrier

Insurance co. name _____ Insurance co. phone _____

Address (Street, City, State, ZIP) _____

Group no. (Plan or Policy no.) _____ Insured's I.D. no. _____

Insured's name _____ Relationship to patient _____

Date of birth _____ Insured's social security no. _____

Insured's employer name _____ Is insured a patient in our practice? ☐ Yes ☐ No

Secondary Carrier

Insurance co. name _____ Insurance co. phone _____

Address (Street, City, State, ZIP) _____

Group no. (Plan or Policy no.) _____ Insured's I.D. no. _____

Insured's name _____ Relationship to patient _____

Date of birth _____ Insured's social security no. _____

Insured's employer name _____ Is insured a patient in our practice? ☐ Yes ☐ No

Person Financially Responsible for Account

Name _____ Relationship to patient _____

Social security no. _____ Phone (____) _____ - _____

Driver's license no. _____ Date of birth _____

Address (Street, City, State, ZIP) _____

Employer _____ Work phone (____) _____ - _____

Preferred payment method: ☐ Cash ☐ Credit Card ☐ Check

Visa/MC/AMEX no. _____ Exp. date _____

If patient is a minor, name of parent or legal guardian and relationship _____

Is this parent or legal guardian currently a patient in our office? ☐ Yes ☐ No

Payment is due in full at the time of treatment

(Unless prior arrangements have been approved)

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective healthcare provider or agency that may release such information to you. I will notify the dentist of any changes in my health or medication.

Signature _____ *Date* _____

Person to contact in case of emergency

Name _____ Relationship _____

City _____ State _____ Cell phone _____

Home phone _____ Work phone _____

Submit

OFFICE USE ONLY

I VERBALLY REVIEWED THE MEDICAL / DENTAL INFORMATION ABOVE WITH THE PATIENT NAMED HEREIN.

Date _____ Initials _____

Patient COVID Screening Form

Patient Name:

	Date:
Are you fully vaccinated for COVID-19?	☐ Yes ☐ No
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	☐ Yes ☐ No
Are you/they having shortness of breath or other difficulties breathing or a cough?	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No
Have you/they experienced recent loss of taste or smell?	☐ Yes ☐ No
Are you/they in contact with any confirmed COVID-19 positive patients in the last 10 days?*Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	☐ Yes ☐ No
Is your/their age over 60?	☐ Yes ☐ No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No
Have you/they traveled in the past 10 days to any regions affected by COVID-19? (as relevant to your location)	☐ Yes ☐ No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

• For testing, see the list of State and Territorial Health Department Websites for your specific area's information.

Signature:_____ Date:_____

In accordance to Health Mandate 15, please inform us if you develop symptoms or are diagnosed with COVID-19 within 48 hours following your appointment.