COMMUNITY ACTION TRI-COUNTY CAP
Serving Coös, Carroll & Grafton County since 1965

TamworthDental
A TRI-COUNTY COMMUNITY ACTION PROGRAM, INC.
448 B White Mountain Hwy, Tamworth, NH 03886 603-323-7645 (323-SMILE)

Tamworth Dental Center New Patient Form

Please print & fill out completely

Patient Information

Name:_____ Birth Date: _____ Sex: ☐ Male ☐ Female
Address:_____ City: _____ State: _____ Zip Code:_____
Cell Phone:_____ Home Phone:_____ Work Phone:_____
Email:_____ Occupation/Employer:_____ Marital Status: ☐ Single ☐ Married
Emergency Contact:_____ Relationship to Patient:_____ Phone:_____
Ethnicity (optional):_____ How were you referred to our practice?_____
Who is responsible for your payment if different from above?_____
Address:_____ City: _____ State: _____ Zip Code: _____
Cell Phone:_____ Email: _____ Birthdate:_____

Dental Insurance Information

Insurance Company:_____ Phone Number: _____
Subscriber's Name:_____ Subscriber's SSN:_____
Group Number:_____ Employer: ID#: _____

Secondary Dental Insurance Information (if applicable)

Insurance Company:_____ Phone Number: _____
Subscriber's Name: _____ Subscriber's SSN: _____
Group Number:_____ Employer: ID#: _____

Dental History

Reason for today's visit:_____
Are you experiencing any dental pain today? ☐YES ☐NO
Former dentist name/practice:_____ Phone: _____
Date of last dental exam:_____ Date of last cleaning:_____
Date of last bitewing radiographs:_____ Date of last full mouth series of radiographs:_____
How often do you brush?_____ How often do you floss? _____

Do you wear dentures or partials?	YES	NO	Any serious injury to your head or mouth?	YES	NO
Have you had periodontal treatment?	YES	NO	Sensitivity to hot/cold/sweets/ or biting?	YES	NO
Have you had orthodontic treatment?	YES	NO	Do your gums bleed?	YES	NO
Have you had any oral surgery/implants?	YES	NO	Any loose teeth, broken fillings?	YES	NO
Do you have pain, popping, clicking of your jaw?	YES	NO	Any sores or growths in your mouth?	YES	NO
Has a physician or previous dentist recommended that you take an antibiotic prior to dental treatment?				YES	NO

Medical History

Name of Primary Care Physician:_____ Date of last visit: _____
Have you ever had any serious illness or operations?:_____
Has there been any change in your general health within the past year or are you being treated for a condition now? ☐YES ☐NO If YES, Please Explain:_____
Please list all Allergies:_____
Medical Insurance Company:_____ Subscriber ID#: _____

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Please circle Yes or No (Y or N) for any illnesses that you currently have or have had in the past.

Heart/Blood Disorders			Immune System Disorders			Behavioral Conditions		
Artificial Heart Valves	Y	N	Allergies	Y	N	Anxiety/Panic Attacks	Y	N
Anemia	Y	N	Myasthenia Gravis	Y	N	Eating Disorder	Y	N
Angina	Y	N	Rheumatoid Arthritis	Y	N	Mental Health Disorder	Y	N
Abnormal Bleeding	Y	N	Sjogren's Syndrome	Y	N	**Substance Use**		
Bacterial Endocarditis	Y	N	Systemic Lupus	Y	N	Alcohol Use	Y	N
Blood Transfusion	Y	N	**Infectious Diseases**			Marijuana Use	Y	N
Circulatory Problems	Y	N	AIDS/HIV	Y	N	Tobacco Use Type: _____	Y	N
Congenital Heart Defects	Y	N	Hepatitis	Y	N			
Congestive Heart Failure	Y	N	Sexually Transmitted Disease	Y	N	Vaping/Juuling	Y	N
Coronary Artery Disease	Y	N	**Other Conditions**			Any other controlled substance use (Please list):_____	Y	N
Heart Attack	Y	N	Artificial Joints Type: _____	Y	N			
Heart Murmurs	Y	N				**Respiratory/ Lung Conditions**		
Heart Surgery	Y	N	Cancer/Chemotherapy/Radiation	Y	N	Asthma	Y	N
Hemophilia	Y	N	Chronic Pain	Y	N	Bronchitis/Tonsillitis	Y	N
High Blood Pressure	Y	N	Glaucoma	Y	N	Emphysema/COPD	Y	N
Low Blood Pressure	Y	N	Kidney Problems/Dialysis	Y	N	Fainting	Y	N
Methemoglobinemia	Y	N	Liver Disease	Y	N	History of Tuberculosis	Y	N
Mitral Valve Prolapse	Y	N	Osteoporosis: Have you taken Bisphosphonates? YES NO	Y	N	**Gastrointestinal Disorders**		
Pacemaker/Defibrillator	Y	N				G.E. Reflux/Heartburn	Y	N
						Inflammatory Bowel Disease	Y	N
Prosthetic Heart Valve	Y	N	Pregnancy/Nursing	Y	N	Ulcers/Gastritis	Y	N
Neurological Disorders			Sleep Apnea	Y	N	**Additional/Other Conditions**		
Epilepsy	Y	N	**Hormonal or Metabolic Disorders**			Please list any other conditions not mentioned above: _____		
Migraine	Y	N	Diabetes: Type I or II	Y	N			
Stroke	Y	N	Thyroid Problem	Y	N			

Please list any medications that you are taking now. Include non-prescription medications, vitamins/ supplements:

Name of Medication	Dose	Reason for taking

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I (or my minor child) has any change in health.

_____ _____ _____

Signature Print Name Date

If you are completing this form for another person, what is your name and relationship to the patient?

Name: _____ Relationship: _____