

Today's Date

\_\_\_\_/\_\_\_\_/\_\_\_\_



Office Use Only

Chart # \_\_\_\_\_ - \_\_\_\_\_

Scanned by \_\_\_\_\_

### New Patient Paperwork

Dr. James Hadley Hall DDS  
 Dr. Thomas Draper DMD, MD  
 Dr. Michael Oppedisano DMD, MS  
 Dr. Michelle Newby DDS, MS  
 Dr. Douglas Baldwin, DDS

### Please circle how you heard about us?

TV	Internet	Newspaper	Radio	Doctor	Friend	NFED	Walk-In
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Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Legal Name \_\_\_\_\_ Gender **Male** **Female**

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Cell \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_

E-Mail \_\_\_\_\_ **Married** **Single** **Divorced** **Widowed**

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Preferred method of Contact **Phone Call** **Text** **Email**

### Health History

1. Do you have any Major Medical Problems? **Yes** **No** Please explain: \_\_\_\_\_

\_\_\_\_\_

2. Are you a smoker? **Yes** **No** If so how much do you smoke daily? \_\_\_\_\_

3. Physicians Name \_\_\_\_\_ Phone Number \_\_\_\_\_

4. Is there any chance you could be pregnant? **Yes** **No** If so how many weeks \_\_\_\_\_

5. Have you been treated for any Periodontal Gum Disease? **Yes** **No** If yes, when \_\_\_\_\_

6. Do you have a family Dentist? **Yes No** Name \_\_\_\_\_ Last Visit \_\_\_\_\_

7. What is your main dental concern today? \_\_\_\_\_

8. Are you currently taking, or have you ever taken, any Bisphosphonates or any other medication for osteoporosis? **Yes No** Please list current or past prescribed Bisphosphonate drug(s)-for example: Actonel, Bonivia, Fosamax \_\_\_\_\_

9. My medical care and additional information regarding appointment, treatment, health care financing, referral information and test results may be discussed with the person listed below.

Name \_\_\_\_\_ Number \_\_\_\_\_ Relationship \_\_\_\_\_

10. Who is accompanying you today? \_\_\_\_\_ Relationship \_\_\_\_\_

11. Which is your chief concern regarding your teeth today.

**Single Tooth Multiple Teeth Top Teeth Bottom Teeth All of the Teeth**

12. Do any of your teeth hurt? **Yes No**

13. On a Scale of **1 (lowest urgency)** to **5 (highest urgency)** where do you rate your current dental condition?

**5 4 3 2 1**

14. When was your last teeth cleaning? **Within a Year Within 5 Years Within 10 Years**

15. Is today's visit a second opinion? **Yes No**

16. Do you wear removable partials? **Yes No**

17. Do you wear removable dentures? **Yes No**

18. Which is your personal dental priority? **Beautiful Smile Restore Function**

19. How often do you think about your dental condition? **Sometimes Most of The Time Constantly**

20. How long have you been thinking about doing a dental procedure? **Days Months Years**

21. How soon are you looking to schedule treatment? **Today 30 days 60 days 90 days**

22. Rate your previous dental visit experiences. **Great Fair Poor Very Bad**

23. Which opportunities do you feel your dental situation causes you to miss out on?

**Health/Diet Dating Social Gatherings Speaking Singing Career Physical Activities**



ARCHPOINT  
Implant Dentistry

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Dr. Michelle Newby DDS, MS  
Dr. Douglas Baldwin, DDS

## FREE 3-D CT SCAN

Your ArchPoint Dentist will interpret the 3-D CT Scan solely for the purpose of evaluating your upper and lower jaw for treatment planning and placement of your dental implants.

It has not been read for the presence of any medical condition. You may want to have this film interpreted by a Physician (Radiologist) of your choosing and at your expense for the presence of any possible medical condition(s).

I have read and elected to take the FREE 3-D CT Scan

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

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**Only sign if you would like a COPY** of your 3-D CT Scan, ArchPoint will provide you with one for a fee. We can refer you to a Maxillofacial Radiologist should you need a referral.

I have elected to take a Copy of the 3-D CT Scan for a fee of **\$300.00**.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_