

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 todays 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. Thomas Draper DMD, MD
Dr. Michael Oppedisano DMD, MS
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: _____

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: _____