Today's Date

_______/______/_______

ARCHPOINT
Implant Dentistry

Office Use Only

_______-____
__________/____

New Patient paperwork

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

Please circle how you heard about us?

TV	Internet	Newspaper	Radio	Doctor

Date of Birth ___________________ **Age** _______

Name ____ Gender ___ Male ___ Female

Address ____

City ___________________________________ State ______________________ Zip Code ____________

Cell __________________________ Home _________________________ Work _______________________

E-Mail _______________________________________ Married __ Single __ Divorced __ Widowed __

Occupation ____ Employer ___________________________

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. How is your current dental condition affecting you? ____

9. How would treating your dental condition change your life? ____

____

10. 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 ____

11. 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 _______________

12. Who is accompanying you today? ____________________________ Relationship____________________

13. How soon would you like to start your dental treatment? _____ Today _____ 30 Days _____ 6 Months

14. Are you interested in patient financing? ____ Yes ___ No

15. Are you interested in a 10% discount for same day start? ____ Yes ____No

Patient Signature ____ **Date** ________________________

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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).

Should you desire, ArchPoint will provide you with a copy of your 3-D CT Scan for a fee of **$500.00**. We can refer you to a Maxillofacial Radiologist should you need a referral for this purpose.

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

Patient Signature: ________________________________ Date: ______________

Print Name: ____