Today's Date

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ARCHPOINT
Implant Dentistry

Office Use Only

Chart # __________-_____
Scanned by _________

New Patient Paperwork

Dr. Thomas Draper DMD, MD
Dr. Kevin Vu, DDS, MS
Dr. Michelle Newby DDS, MS
Dr. Reed Gibbins DMD, MD
Dr. Quinton Slaughter, DDS, MD

Please select how you heard about us?

○ TV	○ Internet	○ Newspaper	○ Radio	○ Doctor	○ Friend	○ NFED	○ Walk-In

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: ____________________

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

3. Do you have a family Dentist? ○ **Yes** ○ **No** Name ______________________ Last Visit __________

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. What is your main dental concern today? ____

☐ **Single tooth** ☐ **Multiple Teeth** ☐ **Top Teeth** ☐ **Bottom Teeth** ☐ **All of the Teeth**

7. 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 ____

8. 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 _____________

9. Who is accompanying you today? ________________________ Relationship__________________

10. Do any of your teeth hurt? ◯ **Yes** ◯ **No**

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

☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5**

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

13. Is todays visit a second opinion? ◯ **Yes** ◯ **No**

14. Do you wear removable partials/dentures? ◯ **Yes** ◯ **No**

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 Name: ______________________________ Date: ___________

Patient Signature: ________________________________ Date: ___________

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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. Speak to your Archpoint Consultant if you would like to take a Copy of the 3-D CT Scan for a fee of $300.00.