Today's Date

_____

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: _____

_____

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.