

Today's Date \_\_\_\_\_



**ARCHPOINT**  
Implant Dentistry

Office Use Only

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

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

## New Patient Paperwork

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

### Please select how you heard about us?

<input type="radio"/> TV	<input type="radio"/> Internet	<input type="radio"/> Newspaper	<input type="radio"/> Radio	<input type="radio"/> Doctor	<input type="radio"/> Friend	<input type="radio"/> NFED	<input type="radio"/> 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. 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 today's 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**.*