New Dental Patient Form

In order to provide you the best possible Dental Care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

New Patient Data

First Name: Gaurav | Last Name: Sekhon | Date: 07-12-2023 | Email*: gaurav.sekhon.38@gmail.com

* Your email will NOT be shared with any 3d parties, and is used for occasional practice announcements and promotions.

Mailing address

Address: 81 Arch St, Apt. 511 | City: Hartford | State: CT | Zip: 06103

Telephone (Work): 646-283-0120 | (home): | Referred By: Sydney app

Age: 32 | Birth Date: 07-05-1991 | Social Security #: 672-33-5310 | Number of Children: 0

Occupation: Doctor | Employer: UConn Health

Marital Status: single | Spouse's Name: n/a | Spouse's Occupation: n/a

Spouse's Employer: n/a | Spouse's Health Status: n/a

Emergency Contact: Sukhbinder / Manjinder Sekhon | Phone: 250-479-9896

Current Complaints

Describe the main purpose of your visit:

?Cavities, very sensitive molars (to pressure and temperature) after fillings several months ago especially.

Have you considered a smile makeover? ○ No ○ Yes

Have you considered Tooth Whitening? ○ No ◉ Yes

Have you ever had cosmetic dentistry? ◉ No ○ Yes

If yes, describe? I don't even know what a smile makeover is

Are you currently experiencing dental pain? ○ No ◉ Yes

If yes, describe: sensitivity

Insurance Information

Name of party responsible for payment: Anthem blue cross blue shield | Phone: 1-800-440-3619

Do you have dental insurance? ○ No ◉ Yes | Name of company: Anthem

Signatures

Name of the insured: Gaurav Sekhon

I understand and agree that dental insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature _____ Date 07-12-2023

Spouse's or guardian's signature _____ Date _____

© Copyright 2010 DentalMatrix

Medical History

Have you been treated for any conditions in the last year? ◉ No ○ Yes

If yes, please describe

Date of last physical exam 06-30-2023

Is there a chance that you are pregnant? ◉ No ○ Yes

Have you had X-rays taken? ◉ No ○ Yes

If Yes, where?

What medications are you taking and for what conditions (Please list dosage and amounts,

sertraline 50 mg daily for anxiety / depression, dextroamphetamine 10 mg BID for ADHD

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency).

Krill oil, SAMe

Family History

Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Misc Pain and Symptoms

Do you experience dental pain every day?	○ No ◉ Yes
Do your symptoms interfere with daily life?	○ No ◉ Yes
Do you grind your teeth at night?	○ No ◉ Yes
Does hot or cold cause pain in your teeth?	○ No ◉ Yes

I think I grind my teeth at night sometimes but obviously cannot be sure as I am generally asleep

Habits	None	Light	Moderate	Heavy
Alcohol	○	○	○	○
Coffee	○	○	○	○
Tobacco	○	○	○	○
Drugs	○	○	○	○
Exercise	○	○	○	○
Sleep	○	○	○	○
Appetite	○	○	○	○
Soft Drinks	○	○	○	○
Water	○	○	○	○
Salty Foods	○	○	○	○
Sugary Foods	○	○	○	○
Artificial Sweeteners	○	○	○	○

© Copyright 2010 DentalMatrix