Welcome to Dental Wellness

PATIENT INFORMATION

First Name: _______________________________ Initial: ______ Last Name: ________________________

Address: ____

City: ____ State: _____ Zip: __________________

Home phone #: ________________________ Work #: ______________ Ext: ___ Cell #: _______________

Social Security #: _______________________ Driver License: ______________________ State: ________

Sex: M/F Birth Date: _________________ ☐Single ☐Married ☐Widowed ☐Divorced

Employer: _______________________________ Occupation: ____

Are you a full time student? Y/N If so, which school? ____

Email: ____

Whom can we thank for referring you? ____

Spouse's Name: ______________________________ Spouse's Social Security #: _____________________

Spouse's Birth Date: _____________________ Spouse's Employer: ____________________________

Spouse's Employers Phone #: _____________________ Occupation: _______________________________

Person to notify in an emergency (not at home address): ____________________ Phone: _____________

Are you interested in a payment plan? Yes/No

MEDICAL HISTORY

Your current physical health is ☐ Good ☐ Fair ☐Poor

Are you currently under the care of a physician? Y/N

If yes, please explain: ____

Physicians name: ____ Phone #:___________________________

Are you taking any medication? Y/N

If yes, please list each one: ____

Allergic to any medication? Y/N If yes, which drugs? ____

Do you require antibiotics before dental treatment: Y/N

Please indicate with a √ if you have OR you have had the following:

- ☐ Allergies to anesthetics
- ☐ Hay fever or allergies in general
- ☐ Any heart ailments (please explain below)
- ☐ High blood pressure
- ☐ Neurological problems
- ☐ Radiation Treatments
- ☐ Excessive bleeding from cut or extraction
- ☐ Anemia or Blood problems
- ☐ Arthritis
- ☐ Immune System Disorders (AIDS/HIV/ARC)
- ☐ Asthma
- ☐ Diabetes
- ☐ Kidney problems
- ☐ Liver problems or hepatitis
- ☐ Malignancies
- ☐ Psychiatric care/ emotional problems
- ☐ Rheumatic fever
- ☐ Sinus problems
- ☐ Stroke
- ☐ Thyroid
- ☐ Eye disorders
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer or Colitis
- ☐ Pregnancy
  Month ___________
- ☐ Venereal disease
- ☐ Other

Please add any information that you feel is important: ____

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DENTAL HISTORY

Reason for visit: ____

Approximate date of last dental visit: ______________________________

Have you ever had any serious problems associated with previous dental treatments? Y/N

If so, please explain: ____

What did or did not happen before at the dentist, that was the reason for you not to return?

____

How often do you brush? ______________ How often do you floss (routinely)? ___________

What type of brush do you use? ☐ Soft ☐ Med ☐ Hard

Do you avoid brushing any part of your mouth? Y/N Where? _____________________________________

Do you ever feel (or been told) that you do not have fresh breath? Y/N

Do you lose fillings or break fillings? Y/N

Do you chew on one side of your mouth? Y/N

Do you usually get a lot of cavities? Y/N

Do your gums feel tender and swollen? Y/N

Do your jaws feel tired? Y/N

Do you have missing teeth? Y/N If, yes did you replace them? Y/N

If not would you like to learn about your options to replace them? Y/N

Do you clench or grind your jaws while you are sleeping or during the day? Y/N

Which food causes you twinges of pain? Hot Cold Sweet None

Please add any information that you feel is important: ____

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I authorize the use of my radiographs and/or photos for use on seminars, publications and the website of Dental Wellness

X____ Date ________________________

Signed (patient or parent of minor)

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

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Signature Date

The highest compliment our patients can give us is the referral of their friends or family. Thank you for your trust.