2200 Westlake Dentistry

*Excellence in Dentistry*

# PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

First Name: _____ M.I. ____ Last Name: _____ Birthdate: _____

Address: _____ City: _____ Zip: _____ State: _____

Home Phone: _____ Cell Phone: _____ Work: _____

SS# _____ Email: _____

(Circle one)
Preferred Contact: Cell Work Home Email Preferred Confirmation Method: Email Text Phone

Gender: Male Female Marital Status: Married Single Divorced Widowed Separated

Whom may we thank for referring you to our office? _____

## RESPONSIBLE PARTY INFORMATION

Name: _____

Employer: _____

SS# _____

## EMERGENCY INFORMATION

Name: _____

Phone: _____

Relation to Patient: _____

## DENTAL INSURANCE INFORMATION

Insured's Name: _____

Insurance Company: _____

Address: _____

Insured's Employer: _____

Insured's SS# or ID #_____

Group # _____

Insured's Date of Birth: _____

## SECONDARY INSURANCE

Insured's Name: _____

Insurance Company: _____

Address: _____

Insured's Employer: _____

Insured's SS# or ID #_____

Group # _____

Insured's Date of Birth: _____

## CONFIRMATION

I certify that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

**Signature of patient (or parent)**_____ **Date:** _____

## MEDICAL INFORMATION- Do you have or have you had any of the following?

| | | |
|---|---|---|
| ☐ Heart problems or disease | ☐ Kidney problems | ☐ Artificial joint/hip replacement |
| ☐ High blood pressure | ☐ Congenital Heart disorder | ☐ Artificial heart valve |
| ☐ Pacemaker | ☐ Heart Attack/Heart failure | ☐ Anxiety/panic disorder |
| ☐ Circulatory problems | ☐ Mitral valve prolapse | ☐ Psychiatric care |
| ☐ Stroke | ☐ Asthma | ☐ Hepatitis A,B or C |
| ☐ Heart murmur | ☐ Sinus problems | ☐ Drug/alcohol addiction |
| ☐ Rheumatic fever | ☐ Sleep apnea | ☐ Epilepsy or seizures |
| ☐ Anemia/bleeding disorder | ☐ Headaches-frequent or severe | ☐ Ulcer |
| ☐ Malignancy (cancer) | ☐ Arthritis | ☐ Diabetes |
| ☐ Radiation therapy | ☐ Aids/HIV positive | ☐ Premedication required? |

Do you have any disease, condition or problem not listed above that you think we should know about? Please explain:

_____

**Are you allergic to or have you had a reaction to:**

| | | |
|---|---|---|
| ☐Local anesthetics | ☐Latex (rubber) | ☐ Penicillin or other antibiotics |
| ☐Sulfa drugs | ☐ Food | ☐Hay fever/seasonal |
| ☐Codeine/other narcotics | ☐ Metals | ☐ Acetaminophen |
| ☐Other: _____ | ☐ Aspirin | ☐ Ibuprofen |

**Please list all medications you are currently taking**:

_____

**During the past twelve months, have you taken any of the following?**

| | | | |
|---|---|---|---|
| ☐Antibiotics | ☐Coumadin | ☐ High Blood Pressure medicine | ☐Cortisone (steroids) |
| ☐Sulfa drugs | ☐Warfarin | ☐ Insulin, Orinase or Similar drug | ☐ Natural remedies |
| ☐Anticoagulants | ☐Plavix | ☐ Controlled substances | ☐ Aspirin |
| ☐Nitroglycerin | ☐ Digitalis | ☐ Ibuprofen | ☐ Fosamax |

**For Women:** Are you pregnant? ☐Yes ☐No How many weeks? _____ Are you nursing? ☐Yes ☐No
Taking birth control pills or hormone replacement? ☐Yes ☐No

Physician Name:_____ Phone: _____Date of last physical _____
Address:_____ City:_____ State: _____ Zip: _____

## DENTAL INFORMATION

When was your last dental visit? _____ Were X-rays taken? ☐Yes ☐No
Name of previous dentist: _____Phone: _____
What is your primary concern? _____

| | | |
|---|---|---|
| Have you ever had trouble getting numb or had reactions to local anesthetic? | ☐Yes | ☐No |
| Do your gums bleed, or feel tender or irritated? | ☐Yes | ☐No |
| Have you ever had any periodontal (gum) treatments | ☐Yes | ☐No |
| Do you have cold sores or ulcers in your mouth? | ☐Yes | ☐No |
| Does food collect between your teeth? | ☐Yes | ☐No |
| Do you have any clicking, popping or discomfort in the jaw? | ☐Yes | ☐No |
| Do you clench or grind your teeth frequently? | ☐Yes | ☐No |
| Are your teeth sensitive to: hot, cold, sweets? | ☐Yes | ☐No |
| Are you satisfied with the appearance of your teeth? | ☐Yes | ☐No |
| Have you ever had a serious injury to your head or mouth? | ☐Yes | ☐No |
| Do you use tobacco (smoking, snuff, chew)? | ☐Yes | ☐No |
| Have you had any problems associated with previous dental treatment? | ☐Yes | ☐No |
| Have you had orthodontic (braces) treatment? | ☐Yes | ☐No |