WISPELWEY DENTAL
FAMILY, COSMETIC & IMPLANT DENTISTRY

PATIENT INFORMATION

Today's Date: _____

Name: _____

Nickname: _____ ❒ Male ❒ Female

Birthdate: ___/___/___ Age: _____

❒ Child/Minor ❒ Single ❒ Married

❒ Divorced ❒ Widowed ❒ Seperated

Other family members seen by us: _____

_____

Previous/Present Dentist: _____

IF MINOR:

School: _____ Grade: _____

CONTACT INFORMATION

Home Address: _____

_____

Home #: (____) _____ Cell #: (____) _____

Email: _____

PARENT INFORMATION

❒ Mother ❒ Father ❒ Step Parent ❒ Guardian

Name: _____ Birthdate: ____/____/____

Home #: (____) _____ Cell #: (____) _____

Email: _____

Employer: _____

❒ Mother ❒ Father ❒ Step Parent ❒ Guardian

Name: _____ Birthdate: ____/____/____

Home #: (____) _____ Cell #: (____) _____

Email: _____

Employer: _____

IN THE EVENT OF AN EMERGENCY

His/Her Name: _____

Phone #: (____) _____ Relation: _____

EMPLOYER INFORMATION

Employer: _____

Employer Address: _____

_____

Work #: (____) _____

Occupation: _____

How long there? _____

SPOUSE INFORMATION

His/Her Name: _____

Birthdate: ____/____/____ Phone #: (____) _____

Employer: _____

INSURANCE INFORMATION

PRIMARY

Dental Coverage: ❒ Yes ❒ No

Insurance Company Name: _____

Insurance Company Address: _____

_____

Insurance Company Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____

Relation: _____ Insured's Birthdate: ____/____/____

Insured's ID#: _____

Insured's Employer: _____

SECONDARY

Dental Coverage: ❒ Yes ❒ No

WHY HAVE YOU COME TO THE DENTIST TODAY?

_____

_____

_____

_____

_____

PHYSICIAN INFORMATION

Do you have a personal physician? ❒ Yes ❒ No

Physician's Name: _____

Phone #: (____) _____ Date of last visit: ____/____/____

Is the patient currently under the care of a physician? ❒ Yes ❒ No

If yes, please explain: _____

_____

The patient's current physical health is: ❒ Good ❒ Fair ❒ Poor

If minor, has your child ever taken Fosamax, or any other bisphoshonate? ❒ Yes ❒ No

If minor, has your child ever taken Phen-Fen? ❒ Yes ❒ No

Are you taking any prescription, over-the-counter or herbal supplements? ❒ Yes ❒ No

Please list each one: _____

_____

MEDICAL HISTORY

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? ❒ Yes ❒ No

Have you ever head any of the following disease or medical problems?

Y	N	Abnormal Bleeding	Y	N	Hepatitis
Y	N	Alcohol/Drug Abuse	Y	N	Herpes/Fever Blisters
Y	N	Anemia	Y	N	High Blood Pressure
Y	N	Arthritis	Y	N	HIV+/AIDS
Y	N	Artificial Bones/Joints/Valves	Y	N	Hospitalized for Any Reason
Y	N	Asthma	Y	N	Kidney Problems
Y	N	Blood Transfusion	Y	N	Liver Disease
Y	N	Cancer/Chemotherapy	Y	N	Low Blood Pressure
Y	N	Colitis	Y	N	Mitral Valve Prolapse
Y	N	Congenital Heart Defect	Y	N	Pacemaker
Y	N	Diabetes	Y	N	Psychiatric Treatment
Y	N	Difficulty Breathing	Y	N	Radiation Treatment
Y	N	Emphysema	Y	N	Rheumatic/Scarlet Fever
Y	N	Epilepsy	Y	N	Seizures
Y	N	Fainting Spells	Y	N	Shingles
Y	N	Frequen Headaches	Y	N	Sickle Cell Disease/Traits
Y	N	Glaucoma	Y	N	Sinus Problems
Y	N	Hay Fever	Y	N	Stroke
Y	N	Heart Attack	Y	N	Thyroid Problems
Y	N	Heart Murmur	Y	N	Tuberculosis (TB)
Y	N	Heart Surgery	Y	N	Ulcers
Y	N	Hemophilia	Y	N	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Erythromycin	Y	N	Metals
Y	N	Codeine	Y	N	Jewelry	Y	N	Penicillin
Y	N	Dental Anesthetics	Y	N	Latex	Y	N	Tetracycline

FOR WOMEN:

Are you using a prescribed method of birth control? ❒ Yes ❒ No

Are you pregnant? ❒ Yes ❒ No

Are you nursing? ❒ Yes ❒ No

CHILD MEDICAL/DENTAL HISTORY

Has the child ever had a serious/difficult problem associated with previous dental work? ❒ Yes ❒ No

Is the child's water fluoridated? ❒ Yes ❒ No

Is the childtaking fluoridated supplements? ❒ Yes ❒ No

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? ❒ Yes ❒ No

Does the child brush his/her teeth daily? ❒ Yes ❒ No

Does the child floss his/her teeth daily? ❒ Yes ❒ No

Has the child ever had any of the following medical problems?

Y	N	ADD/ADHD	Y	N	Autism
Y	N	Any Hospital Stays	Y	N	Convulsions/Epilepsy
Y	N	Any Operations	Y	N	Handicaps/Disabilities
Y	N	Asperger Syndrome	Y	N	Hearing Impairment

Please discuss any problems that the child has had: _____

_____

Does/did the child have any of the following habits?

Y	N	Lip Sucking/Biting	Y	N	Nursing Bottle Habits
Y	N	Nail Biting	Y	N	Thumb/Finger Sucking

DENTAL HISTORY

Do you require antibioticcs before dental treatment? ❒ Yes ❒ No

Are you currently in pain? ❒ Yes ❒ No

Do your gums ever bleed? ❒ Yes ❒ No

Have you ever had a serious/difficult problem associated with any previous dental work? ❒ Yes ❒ No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ❒ Yes ❒ No

Your current dental health is: ❒ Good ❒ Fair ❒ Poor

Rate your smile (dislike to like): **1 2 3 4 5 6 7 8 9 10**

Would you like whiter teeth?

Would you like fresher breath?

How many times a week do you floss?____ a day do you brush? ____

Type of bristles? ❒ Soft ❒ Medium ❒ Hard

Do you smoke or use tobacco in any other form? ❒ Yes ❒ No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____ _____

Signature Date