Wendel Family Dental Centre Patient Information

Name: _____ _____ _____
FIRST NAME M.I. LAST NAME

I prefer to be called _____ □ M □ F

Birth date _____ SS # _____

□ Single □ Married □ Divorced □ Widowed □ Separated

Mailing Address: _____

City _____ State____ Zip _____

Physical Address (if different): _____

_____

Home #:(____)_____ Work #:(____)_____

Mobile #:(____)_____ Other #:(____)_____

Employer: _____ How Long? _____

May we call you at work? □ Yes □ No

Best time to reach you and at which phone number?

□ AM □ Afternoon □ PM **AND** □ Home □ Work □ Mobile □ Other

Email Address: _____

Who may we THANK for referring you? _____ _____
FIRST NAME LAST NAME

Do you have any family members that come to Wendel?

If so, who? _____

Name of Person Financially Responsible: _____ _____
FIRST NAME LAST NAME

Relationship to Patient: □ Self □ Spouse □ Parent □ Other: _____

If child, lives with: □ Both Parents □ Mom □ Dad □ Other

PARENT/GUARDIAN INFORMATION:

Name: _____ □ M □ F

Home Address: _____

_____

Home #: _____ Work #: _____

Employer: _____

Birth date _____ SS # _____

SPOUSE OR ADD'L PARENT/GUARDIAN INFORMATION:

Name: _____ □ M □ F

Home Address: _____

_____

Home #: _____ Work #: _____

Employer: _____

Birth date _____ SS # _____

DENTAL INSURANCE

Primary Dental Insurance

Ins. Co. : _____

Ins. Address: _____
STREET ADDRESS

_____ _____ _____
CITY STATE ZIP CODE

Ins. Phone 1: (_____) _____

Policy Holder: _____ _____
FIRST NAME LAST NAME

Group #: _____

Policy Holder's Address if different from left: _____
STREET ADDRESS

_____ _____ _____
CITY STATE ZIP CODE

Phone #: (_____) _____

Relationship to Patient: □ Self □ Spouse □ Parent □ Other: _____

Birth date _____ SS # _____

Insured's Employer: _____

Secondary Dental Insurance

Ins. Co. : _____

Ins. Address: _____
STREET ADDRESS

_____ _____ _____
CITY STATE ZIP CODE

Ins. Phone 1: (_____) _____

Policy Holder: _____ _____
FIRST NAME LAST NAME

Group #: _____

Policy Holder's Address if different from left: _____
STREET ADDRESS

_____ _____ _____
CITY STATE ZIP CODE

Phone #: (_____) _____

Relationship to Patient: □ Self □ Spouse □ Parent □ Other: _____

Birth date _____ SS # _____

Insured's Employer: _____

EMERGENY CONTACT INFO:

In the event of an emergency, is there someone who lives near you that we should contact?

Name: _____ Relation: _____

Wk #:(____)_____ Hm #:(____)_____

Person Filling Out Form: _____

Signed: _____

Date: _____ Relation: _____

Updated: 2/1/07

Wendel Family Dental Centre
HEALTH HISTORY

Patient's Name | Date | FIRST NAME LAST NAME Previous Dentist | Last dental appointment

Answer all questions by checking Yes (Y) or No (N) Y N

Are you in good health? ☐ ☐
Has there been any change in your general health in the past year? ☐ ☐
Do you have a personal physician? ☐ ☐
Name: _____ _____ Phone #: _____
FIRST NAME LAST NAME
Date of last physical exam: _____
Are you now under a physician's care for a particular problem? ☐ ☐
Have you ever had any serious illnesses, operations or hospitalizations?
If so, describe: _____ ☐ ☐
Height: _____ Weight: _____
Do your gums ever bleed? ☐ ☐
I brush _____ times a week and floss _____ times a week.
Are you currently in pain? ☐ ☐
Are you apprehensive about dental work?
☐ No ☐ Slight ☐ Moderate ☐ Extreme
Are you interested in sedation dentistry? ☐ ☐
How long has it been since you had your teeth cleaned?
☐ 3-5 months ☐ 6-9 months ☐ 10-12 months ☐ _____years ☐ Never
Are you interested in learning more about:
☐ Invisalign ☐ Teeth Whitening ☐ Implants ☐ Orthodontics
How often do you visit the dentist? ☐ Never ☐ Checkups ☐ Regularly

DO YOU HAVE OR HAVE YOU EVER HAD: Y N
** = Click on each problem/matter within question.

Rheumatic Fever or Rheumatic Heart Disease? ☐ ☐
Congenital Heart Disease? ☐ ☐
** Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker, Mitral Valve Prolapse?) ☐ ☐
** Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? ☐ ☐
** Seizures, Convulsions, Epilepsy, Fainting or Dizziness? ☐ ☐
** Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? ☐ ☐
Liver Disease, Jaundice, Hepatitis A, Hepatitis B, Hepatitis C? ☐ ☐
Kidney Disease? ☐ ☐
Arthritis? ☐ ☐
Diabetes? (☐ Diet Controlled ☐ Meds Controlled) ☐ ☐
Thyroid Disease, Goiter? ☐ ☐
Stomach Ulcers, Colitis? ☐ ☐
Glaucoma? ☐ ☐
Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? ☐ ☐
Chemo or Radiation treatment for Cancer? ☐ ☐
Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? ☐ ☐
Sinus or Nasal problems? ☐ ☐
Any disease, drug or transplant operation that has depressed your immune system (HIV/AIDS)? ☐ ☐

OFFICE USE ONLY * OFFICE USE ONLY

MEDICAL UPDATE: I have read my Health History dated _____ and confirm that it adequately states past and present conditions.

Date | Signature of Person Completing Form | Dr's Initials
Changes: _____

Date | Signature of Person Completing Form | Dr's Initials
Changes: _____

Print Form

ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO: Y N

Local Anesthesia (Novocain, etc.)? ☐ ☐
Penicillin or other antibiotics? ☐ ☐
Sedatives, Barbiturates? ☐ ☐
Aspirin or Ibuprofen? ☐ ☐
Codeine or other pain killers? ☐ ☐
Latex or Rubber Products? ☐ ☐
Other allergies or reactions? Please, list:

ARE YOU USING ANY OF THE FOLLOWING: Y N

Antibiotics? ☐ ☐
Anticoagulants (Blood Thinners)? ☐ ☐
Aspirin or drugs such as Motrin, Aleve, Ibuprofen? ☐ ☐
High Blood Pressure medications? ☐ ☐
Steroids (Cortisone, etc.)? ☐ ☐
Weight loss medications (Fen-Fen)? ☐ ☐
Tranquilizers and/or antidepressants? ☐ ☐
Insulin or Oral Anti-Diabetic drugs? ☐ ☐
Digitalis, Inderal, Nitroglycerin or other heart drug? ☐ ☐
Are you taking or have you ever taken Bisphosphonates (such as Fosamax or Actonel for osteoporosis, or chemotherapy for multiple myeloma, etc.)? ☐ ☐
Recreational Drugs? ☐ ☐
Please list any and all medications taken, including prescription and over-the-counter medications, herbal or holistic remedies, vitamins or minerals:

Have you ever smoked or chewed tobacco? ☐ ☐
How much per day? _____ How long? _____
Do you have a history of Alcohol or Chemical Dependency or Emotional Disorder? ☐ ☐
Have you had any serious problems associated with any previous dental treatment? ☐ ☐
Have you or an immediate family member had any problem associated with intravenous anesthesia? ☐ ☐
Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ☐ ☐
Do you wish to talk to the doctor privately about anything? ☐ ☐

FOR WOMEN ONLY: Y N

Are you Pregnant or is there any chance you might be Pregnant? ☐ ☐
Are you nursing? ☐ ☐
If you are using Oral Contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Health History with my doctor.

Date | Signature of Person Completing Form | Dr's Initials

Submit Form