|  |
| --- |
| **Logo  Description automatically generated** |
| **NEW Patient FormS** |

About You

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ | | | | | |
| Name: |  |  | |  | Birthdate: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_ |
|  | Last | First | | M. I. |  |
| Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Sex: ❑ F ❑ M |  |  |
| Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed | | | | | |
| Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | Apt/Condo #: \_\_\_\_\_\_\_\_\_ | |
| City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_ | | | | Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| Employer Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_ | | | | | |
| Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ext: \_\_\_\_\_\_\_\_\_ | | | | | |

Spouse Information

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name: |  |  | |  | Birthdate: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_ |
|  | Last | First | | M. I. |  |
| Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Sex: ❑ F ❑ M | Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| Employer Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_ | | | | | |
| Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ext: \_\_\_\_\_\_\_\_\_ | | | | | |

Person Financially Responsible

|  |  |
| --- | --- |
| ❑ Self | |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ext: \_\_\_\_\_\_\_ |
| Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Billing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_ | |

Primary Dental Insurance

|  |  |
| --- | --- |
| Insured’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Insured’s Birthdate: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_ | Insured’s SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Insured’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Insurance Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_ | |
| Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| ID # or Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Secondary Dental Insurance

|  |  |
| --- | --- |
| Insured’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Insured’s Birthdate: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_ | Insured’s SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Insured’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Insurance Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_ | |
| Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| ID # or Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Emergency Contact Information

|  |  |
| --- | --- |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

Authorization of Personal Information

|  |  |
| --- | --- |
| The following persons may be contacted to discuss my dental treatment plan at Wood Family Dentistry: | |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

Dental History

|  |  |
| --- | --- |
| How did you hear about Wood Family Dentistry: ❑ Google ❑ Yelp ❑ Facebook ❑ Instagram  ❑ Friend: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❑ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Previous Dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| When was your last dental visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Reason for todays visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Are you currently in pain? ❑ No ❑ Yes – Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Do you require antibiotics before dental treatment? ❑ No ❑ Yes – ❑ Amoxicillin ❑ Clindamycin ❑ Other \_\_\_\_\_\_\_\_ | |
| Have you had a serious/difficult problem associated with any previous dental work? ❑ No ❑ Yes | |
| Do you experience, or have you experienced pain or discomfort with you jaw joint (TMJ/TMD)? ❑ No ❑ Yes | |
| Do you like your smile? ❑ No ❑ Yes |  |
| Would you like whiter teeth? ❑ No ❑ Yes |  |
| Do your gums bleed? ❑ No ❑ Yes |  |
| How many times a day do you brush? \_\_\_\_\_ |  |
| How many times a week do you floss? \_\_\_\_\_ |  |
| Type of toothbrush? ❑ Manual ❑ Electric |  |

Medical History

|  |  |  |
| --- | --- | --- |
| Do you now or have you ever been diagnosed or had: | | |
| ❑ Alcohol/Drug abuse | ❑ Emphysema | ❑ Kidney Problems |
| ❑ Anemia | ❑ Epilepsy/Seizures | ❑ Liver Problems |
| ❑ Arthritis | ❑ Excessive bleeding | ❑ Low blood pressure |
| ❑ Artificial Joints \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ❑ Fever blisters/ Herpes/ Cold sores | ❑ Mental Disorders \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ❑ Artificial heart valves | ❑ Glaucoma | ❑ Mitral Valve Prolapse |
| ❑ Asthma | ❑ Heart attack | ❑ Pacemaker |
| ❑ Bisphosphonate | ❑ Heart murmur | ❑ Radiation Treatment \_\_\_\_\_\_\_\_\_\_\_ |
| ❑ Blood thinners \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ❑ Heart surgery | ❑ Respiratory Problems |
| ❑ Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ❑ Hemophilia | ❑ Stroke |
| ❑ Diabetes, HbA1c: \_\_\_\_\_ | ❑ Hepatitis (A) (B) (C) | ❑ Thyroid (Hyper) (Hypo) |
| ❑ Difficulty breathing | ❑ Hypertension | ❑ Ulcers/Colitis/Crohn’s |
| ❑ Dizziness/Fainting | ❑ HIV+/AIDS | ❑ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| For Women: | ❑ Currently Pregnant | ❑ Currently Breastfeeding |

Medical History Continued

|  |  |  |
| --- | --- | --- |
| Do you use nicotine products? ❑ No ❑ Yes: ❑ Cigarettes \_\_\_\_\_ pack/day ❑Cigar ❑ Pouch/Dip ❑ Vape | | |
| Do you have allergies or negative reactions to any of the following: | | |
| ❑ Aspirin | ❑ Erythromycin | ❑ Sulfa |
| ❑ Codeine | ❑ Metals/ Jewelry | ❑ Tetracycline |
| ❑ Clindamycin | ❑ Latex | ❑ Other: |
| ❑ Dental Anesthetics | ❑ Penicillin |  |

Surgical History

|  |  |
| --- | --- |
| Date | Surgery |
|  |  |
|  |  |
|  |  |
|  |  |

Pharmacy & Medications

|  |  |
| --- | --- |
| Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_ | |
| Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements: | |
| Name of medication | Dose (include strength & number of pills per day) |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

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.

|  |
| --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Patient/ Guardian Signature Date |