Patient's First Name:_____ Last Name:_____ Middle Initial:__ Preferred Name:_____
Patient is: □ Policy Holder □ Responsible Party
Address:_____ City:_____ State:_____
Zip:_____ Home Phone:_____ Work Phone: _____ Cell Phone:_____
Sex: □ Male □ Female Marital Status: □ Married □ Single □ Divorced □ Separated □ Widowed
Date of Birth:_____ SSN:_____ Email:_____Email confirmations? Yes □ No □
Employer:_____ Emergency Contact:_____ Phone:_____

Responsible Party (if other than patient) First Name: _____ Last Name:_____Middle Initial:___
Relationship to Patient: □ Self □ Spouse □ Parent □ Other Responsible Party Date of Birth:_____
SSN:_____ Address:_____ City:_____ State:_____ Zip:_____
Employer:_____ Email:_____

Primary Insurance Company:_____
Policy Holder's relationship to Patient: □ Patient □ Spouse □ Parent □ Other
If not Patient, Insured's Name:_____ Employer: _____ Date of Birth:_____
SSN:_____ Group #:_____ ID #:_____

Secondary Insurance Company:_____
Policy Holder's relationship to Patient: □ Patient □ Spouse □ Parent □ Other
If not Patient, Insured's Name:_____ Employer:_____ Date of Birth:_____
SSN:_____ Group #:_____ ID #:_____

Personal
How did you hear about our office (referral source)?_____
How can we make your visit the best you have had?_____

Dental Information
Reason for today's visit: _____ Date of last dental exam:_____
What was done at your last visit?_____
How often do you brush?_____ Floss?_____

Are any of your teeth sensitive to hot or cold? □ Yes □ No
Would you like your teeth whiter? □ Yes □ No
Are any of your teeth sensitive to sweets/pressure?
□ Yes □ No
Are you concerned about chips in your teeth? □ Yes □ No

Ever had problems with local anesthetic? □ Yes □ No
Have you been treated for gum disease? □ Yes □ No
Are you concerned about bad breath? □ Yes □ No
Have you ever had an unfavorable dental visit? □ Yes □ No

AUTHORIZATION FOR TREATMENT AND SURGICAL CARE:

I hereby grant permission to the staff of Woodland Park Dental to employ such established treatments and therapy as may be deemed professionally necessary or advisable. I have been informed that I have rights to privacy regarding my protected health information, and I have been given the opportunity to review this offices Notice of Privacy Practices as required by Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to: provide and coordinate treatment among health care providers who may be involved in my care, obtain payment information from third-party payers for my health care services, and conduct normal health care operations.

Parent/Guardian or Patient Signature: _____ Date: _____

Patient Health History

Patient Name:_____ Birth Date:_____

Are you under a physician's care now □Yes □No
If yes, please explain:_____

Have you ever been hospitalized or had a major operation? □Yes □No
If yes, please explain: _____
_____

Are you taking any medications, pills, or drugs? □Yes □No If yes, please list drugs and what they are for:_____
_____

Have you ever taken Fosamax, Boniva, Actonel, or any other drugs containing bisphosphonates? □ Yes □ No
Are you taking any blood thinners (eg. Coumadin, Eliquis, Xarelto, etc.)? □ Yes □ No
Do you use controlled substances? □Yes □No
Do you use tobacco?. □Yes □No If yes, how often and what type:_____

WOMEN- Are you: □Pregnant/Trying to get Pregnant? □Nursing? □Taking oral contraceptives?
Are you allergic to any of the following? □ Aspirin □ Penicillin □ Codeine □ Acrylic □ Metal □ Latex □ Local Anesthetics □ Sulfa Drugs □ Other—If yes, please explain:_____
_____

Do you have, or have you had, any of the following?

□ AIDS/HIV
□ Drug Addiction
□ Hemophilia
□ Alzheimer's disease
□ Epilepsy or Seizures
□ Irregular Heartbeat
□ Anemia
□ Excessive Bleeding
□ Kidney Problems- Dialysis?
□ Angina
□ Fainting Spells/Dizziness

□ Leukemia
□ Arthritis/ Gout
□ Frequent Headaches
□ Lichen Planus

□ Artificial Heart Valve
□ Glaucoma
□ Liver Disease
□ Artificial Joint
□ Heart Pace Maker
□ Lung Disease
□ Asthma
□ Heart Murmur
□ Mitral Valve Prolapse

□ Breathing Problems
□ Heart Attack/ Failure

□ Osteoporosis
□ Bruise Easily
□ Hepatitis A

□ Psychiatric Care
□ Cancer
□ Hepatitis B or C
□ Sinus Trouble
□ Chemotherapy and/or Radiation
□ Herpes Type I
□ Sjogren's Disease
□ Cold Sores/Fever Blisters
□ Herpes Type II
□ Stroke
□ Congenital Heart Disorder
□ High Cholesterol
□ Thyroid Disease
□ Diabetes (Type 1 or 2?)
□ High Blood Pressure
□ TMJ issues

Have you ever had any serious illness not listed above? □Yes □No If yes, please explain:_____
_____
Date of your last medical examination:_____ Physician's Name: _____Phone Number: _____

To the best of my knowledge, the questions on the form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient or Parent/Guardian Signature:_____ Date:_____