WEST RANCH DENTAL CENTER

PATIENT INFORMATION

Today's Date:_____

Patient's Name:_____ SS #: _____

Birth date: _____ Sex: **M** **F** Marital Status:_____ Spouse Name:_____

Address:_____ City:_____ Zip:_____

Home #_____ Work #_____ Cell #_____ Email:_____

Employer _____ ***OR*** School _____ □ Full time □ Part time

Who may we thank for referring you?_____ □ Yellow Pages □ Location □ Other

RESPONSIBLE PARTY INFORMATION *(If different from the patient)*

Name:_____ Marital Status:_____ Spouse Name:_____

Address:_____ City:_____ Zip:_____

Home #: _____ Work #: _____ Cell #:_____

Social Security #:_____ Birth Date:_____ Relation to patient:_____

MEDICAL HISTORY

- Personal Physician: _____ Phone: _____
- Are you currently under the care of a physician? □ Yes □ No

  ***If yes, please explain*:** _____
- Have you ever been hospitalized? □Yes □ No

  ***If yes, please explain*:** _____
- Please list all medications you are currently taking including **PRESCRIPTIONS, OVER THE COUNTER & NATURAL MEDICATIONS**:

  _____

  _____

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING? CHECK *YES* OR *NO* .

□ Yes □ No **Aspirin** □ Yes □ No **Codeine** □ Yes □ No **Penicillin** □ Yes □ No **Erythromycin**

□ Yes □ No **Local Anesthesia** □ Yes □ No **Nitrous Oxide** □ Yes □ No **Metals** □ Yes □ No **Latex Products (Gloves)**

□ Yes □ No **Other Medications or Substances**_____

CHECK *YES* OR *NO* OF THE FOLLOWING WHAT YOU HAVE HAD OR PRESENTLY HAVE:

□ Yes □ No Heart Attack / Stroke
□ Yes □ No Cancer / Chemotherapy
□ Yes □ No Heart Murmur
□ Yes □ No Rheumatic Fever
□ Yes □ No Mitral Valve Prolapse
□ Yes □ No Hepatitis A, B, C or D
□ Yes □ No Anemia
□ Yes □ No HIV / AIDS
□ Yes □ No Artificial Bones / Joints
□ Yes □ No Thyroid Disorder
□ Yes □ No Venereal Disease
□ Yes □ No Heart Surgery
□ Yes □ No Pace Maker
□ Yes □ No Psychiatric Problems

□ Yes □ No Epilepsy
□ Yes □ No Seizures
□ Yes □ No Fainting
□ Yes □ No Diabetes
□ Yes □ No Tuberculosis
□ Yes □ No Hemophilia
□ Yes □ No High Blood Pressure
□ Yes □ No Low Blood Pressure
□ Yes □ No Radiation Treatments
□ Yes □ No Asthma
□ Yes □ No Frequent / Severe Headaches
□ Yes □ No Emphysema
□ Yes □ No Breast Implants
□ Yes □ No **Any conditions not listed?**

_____

DO YOU TAKE ANY OF THE FOLLOWING:

□ Yes □ No Blood thinners
□ Yes □ No Gingko
□ Yes □ No Ginseng
□ Yes □ No Ginger
□ Yes □ No Garlic
□ Yes □ No Kava
□ Yes □ No St John's Wort
□ Yes □ No Energy or Diet Supplements
□ Yes □ No Vitamins
□ Yes □ No Insulin
□ Yes □ No Use an Inhaler
□ Yes □ No Premedication

DENTAL HISTORY ***PLEASE √ YES OR NO TO THE FOLLOWING QUESTIONS***

Do you have a specific dental problem? Describe_____ □ Yes □ No

Are your teeth sensitive to: □ **HOT** □ **COLD** □ **SWEETS** □ **PRESSURE** _____ □ Yes □ No

Do you have dental examinations on a routine basis? _____ □ Yes □ No

Do you brush and floss on a routine basis? _____ □ Yes □ No

Have you ever been told you have or have had **PERIODONTAL (GUM)** disease?_____ □ Yes □ No

Do your gums ever □ **BLEED**, feel □ **TENDER** or □ **IRRITATED**? _____ □ Yes □ No

Are you unhappy with the APPEARANCE of your teeth? Why ?_____ □ Yes □ No

Does food catch between your teeth? _____ □ Yes □ No

Any loose teeth?_____ □ Yes □ No

Do you want to keep your remaining teeth?_____ □ Yes □ No

Do you ever have clicking, popping or discomfort in the jaw joint?_____ □ Yes □ No

Do you **CLENCH** or **GRIND** your teeth?_____ □ Yes □ No

Have your past experiences in a dental office always been positive?_____ □ Yes □ No

Are you apprehensive about dental treatment?_____ □ Yes □ No

Do you use tobacco products? □ Cigarettes □ Chew _____ □ Yes □ No

Have you worn BRACES on your teeth (ORTHODONTICS)?_____ □ Yes □ No

Name of previous Dentist_____ Phone_____

What is most important to you in your dental health?

DENTAL INSURANCE INFORMATION (Primary Carrier)

INSURANCE CO. _____

INSURANCE CO. TELEPHONE:_____

INSURED'S EMPLOYER: _____

INSURED'S NAME: _____

D.O.B. _____ SS #: _____

DENTAL INSURANCE INFORMATION (Secondary Carrier)

INSURANCE CO. _____

INSURANCE CO. TELEPHONE:_____

INSURED'S EMPLOYER: _____

INSURED'S NAME: _____

D.O.B. _____ SS #: _____

I have provided my MEDICAL and DENTAL history to the best of my knowledge. I understand that West Ranch Dental is willing to submit dental claims on my behalf to my dental insurance, based on the information I provide. I acknowledge that payment for services are my obligation REGARDLESS OF INSURANCE or any other third-party involvement.

SIGNATURE: **DATE:**