ADA American Dental Association®
America's leading advocate for oral health

Today's Date: ____________________

Patient Dental & Medical Health History Information

To our patients: Please know that we may ask follow-up questions to make sure we have all of the information we need in order to treat you.

PATIENT INFORMATION

Last Name: First Name: Middle Name:

Home Phone: Cell Phone: Work Phone:

Email Address:

Mailing Address: City: State: Zip:

Date of Birth: / / Gender:

Occupation:

Emergency Contact: Name: Relationship: Phone:

If you are completing this form for another person, what is your name and relationship to that person? Name: ____________________ Relationship: __________

If executing this form as the patient's personal representative, I represent and warrant that I have full legal right and authority to consent to the performance of any procedure(s) on this patient. If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing.

DENTAL HISTORY & SYMPTOMS

What is the reason for your visit today?

Are you currently experiencing any dental pain or discomfort? ☐ Yes ☐ No If yes, where?

When was your last dental exam? / / What was done at that appointment?

When was the last time you had dental x-rays taken?

Please mark an "X" in the box ONLY if this applies to you.

Is it hard to open your mouth? ☐

Does it hurt to chew, bite or swallow? ☐

Do your gums bleed when you brush or floss your teeth? ☐

Have you ever had periodontal (gum) treatments like scaling and root planing? ☐

Do you have, or have you ever had, any sores or growths in your mouth? ☐

Do you clench or grind your teeth? ☐

Does your jaw click, pop or hurt? ☐

Do you have earaches or neck pains? ☐

Does dental treatment make you nervous? ☐

Have you ever experienced any of these sleep-related breathing disorders? ☐
☐ Mouth breathing ☐ Snoring ☐ Trouble breathing during sleep

Have you ever had a serious injury to your head or mouth? ☐
If yes, please describe what happened and when it happened: ____________________

Have you ever had problems with dental treatment in the past? ☐
If yes, please describe what happened: ____________________

Have you ever had a reaction to, or problem with, dental anesthesia? ☐
If yes, please describe what happened: ____________________

Are you unhappy with your smile? ☐
If yes, why? Please mark all that apply:
☐ The color of your teeth ☐ The shape of your teeth ☐ The position of your teeth
☐ Other. Please describe: ____________________

MEDICATIONS & OTHER PRODUCTS/SUBSTANCES

Please use an "X" to mark your answers to the following questions. Yes No ?

Are you taking any **blood thinners** (such as Coumadin, Warfarin, rivaroxaban (Xarelto®), dabigatran (Pradaxa®), clopidogrel (Plavix®), heparin or aspirin)? ☐ ☐ ☐

If yes, what medication are you taking? ____________________

Are you taking any medication to treat **osteoporosis** or Paget's disease? ☐ ☐ ☐

Some commonly-prescribed drugs include alendronate (Fosamax®), risedronate (Actonel®), ibandronate (Boniva®), zolendronate (Reclast®), and denosumab (Prolia®).

If yes, what medication are you taking? ____________________

Are you taking, or scheduled to take, an **IV medication** to treat bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ ☐ ☐

Some commonly-prescribed drugs include denosumab (Xgeva®), pamidronate (Aredia®) or zolendronate (Zometa®).

If yes, what medication are you taking? ____________________ How many years have you been taking it? __________

Are you taking **hormonal replacements**? ☐ ☐ ☐

Do you use any form of **tobacco or nicotine products** (cigarettes, cigars, snuff, chew, bidis)? ☐ ☐ ☐

Do you use **vaping products**? ☐ ☐ ☐

How many **alcoholic beverages** do you have per week? __________

Do you use **controlled substances** (drugs), including marijuana, for either medicinal or recreational reasons? ☐ ☐ ☐

If yes, what substances? ____________________ If yes, how often is your use? ☐ Daily ☐ Several times per week ☐ Weekly ☐ Occasionally

Was the substance prescribed by a doctor? ☐ Yes ☐ No If yes, for what reason(s)? ____________________

Do you take any other **prescriptions and/or over-the-counter medicine(s), vitamins, herbs and/or supplements?** ☐ ☐ ☐

If yes, please list them here and include information about how much and how often you use each one. ____________________

WOMEN ONLY: Are you:

Taking **birth control pills**? ☐ ☐ ☐

Pregnant? If yes, number of weeks: __________ ☐ ☐ ☐

Nursing? If yes, number of weeks: __________ ☐ ☐ ☐

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ALLERGIES Please use an "X" to mark your answers to the following questions.

Are you allergic to or have you had an allergic reaction to:

	Yes	No	?
Aspirin	☐	☐	☐
Barbiturates, sedatives or sleeping pills	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Hay fever/seasonal allergies	☐	☐	☐
Iodine	☐	☐	☐
Latex (rubber)	☐	☐	☐
Local anesthetics	☐	☐	☐
Metals	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐
Sulfa drugs such as sulfamethoxazole-trimethoprim (Septra, Bactrim), erythromycin-sulfisoxazole, sulfasala-zine (Azulfidine), erythromycin-sulfisoxazole (Eryzole, Pediazole) glyburide (Diabeta, Glynase PresTabs), dapsone, sumatriptan (Imitrex), celecoxib (Celebrex), hydrochlorothiazide (Microzide) and furosemide (Lasix)	☐	☐	☐
Other	☐	☐	☐

Please describe any "Yes" answers and include information about your experience. ______

MEDICAL & SURGICAL HISTORY

Date of last physical exam: / /

What is your normal blood pressure (systolic, diastolic)?

Doctor's Name:

Phone:

Please use an "X" to mark your answers to the following questions.

	Yes	No	?
Are you in good physical health?	☐	☐	☐
Are you currently being seen or treated by a physician?	☐	☐	☐
Has a physician or previous dentist recommended that you take **antibiotics** before having dental work done?	☐	☐	☐
Have you had a **serious illness, operation or been hospitalized** in the past 5 years?	☐	☐	☐
Have you had any type (either total or partial) of **joint replacement** surgery (such as for a hip, knee, shoulder, elbow, finger, etc.)?	☐	☐	☐
Have you had a **heart valve replacement or heart surgery**?	☐	☐	☐
Have you had an **organ or bone marrow/stem cell transplant**?	☐	☐	☐
Have you traveled internationally within the last 30 days	☐	☐	☐
Have you had a fever (100.4°F or above) in the last 72 hours?	☐	☐	☐

If you answered yes to any of the above, please explain: ______

MEDICAL HISTORY SPECIFIC Please use an "X" to mark your answers to the following questions.

Do you have, or have you been diagnosed with, any of the following conditions?

Heart (Cardiac) Health	Yes	No	?
Pacemaker/implanted defibrillator	☐	☐	☐
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Congenital heart disease (CHD)	☐	☐	☐
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Coronary artery disease	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur/rhythm disorder	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Stroke	☐	☐	☐
Breathing (Respiratory) Health			
Asthma (COPD)	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐

	Yes	No	?
Cancer	☐	☐	☐
Type: ______			
Date of diagnosis: ______			
Chemotherapy: ______			
Radiation treatment: ______			
Blood (Circulatory) Health			
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: ______			
Hemophilia	☐	☐	☐
High or low blood pressure	☐	☐	☐
Brain (Neurological)/Mental Health			
Anxiety	☐	☐	☐
Depression	☐	☐	☐
Epilepsy	☐	☐	☐
Mental health disorders	☐	☐	☐
Neurological disorders	☐	☐	☐
Post-traumatic stress disorder	☐	☐	☐
Traumatic brain injury or concussion	☐	☐	☐
Autoimmune Disease			
AIDS or HIV Infection	☐	☐	☐
Lupus	☐	☐	☐

Digestive Health	Yes	No	?
Gastrointestinal disease	☐	☐	☐
G.E. reflux/persistent heartburn (GERD)	☐	☐	☐
Stomach ulcers	☐	☐	☐
Eye (Vision) Health			
Glaucoma	☐	☐	☐
Other			
Arthritis	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes (type I or II)	☐	☐	☐
Eating disorder	☐	☐	☐
Frequent infections	☐	☐	☐
Type of infection: ______			
Hepatitis, jaundice or liver disease	☐	☐	☐
Immune deficiency	☐	☐	☐
Kidney problems	☐	☐	☐
Malnutrition	☐	☐	☐
Osteoporosis	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Sexually transmitted infection (STI)	☐	☐	☐
Thyroid problems	☐	☐	☐

Do you have any disease, condition, or problem that's not listed here? If so, please explain. ______

MEDICAL SYMPTOMS/GENERAL Please use an "X" to mark your answers to the following questions.

In the past 30 days, have you:

	Yes	No	?
had pain or tightness in the chest?	☐	☐	☐
coughed up blood or had a cough that lasted longer than 3 weeks?	☐	☐	☐
been exposed to anyone with tuberculosis?	☐	☐	☐
had a rapid or irregular heart beat?	☐	☐	☐
found it hard to catch your breath?	☐	☐	☐
had a high fever (greater than 101.5°F) for no reason?	☐	☐	☐
noticed a change in your vision?	☐	☐	☐
fainted for no reason?	☐	☐	☐
experienced vomiting, diarrhea, chills, night sweats or bleeding?	☐	☐	☐
had migraines or severe headaches?	☐	☐	☐

NOTE: It's important for both the doctor and patient to talk honestly about the patient's health before dental treatment starts.
I have answered the above questions completely, accurately and to the best of my ability.

Signature of Patient/Legal Guardian: ______ Date: ______

FOR COMPLETION BY DENTIST

Comments: ______

Office Use Only: ☐ Medical Alert ☐ Premedication ☐ Allergies ☐ Anesthesia

Reviewed by: ______ Date: ______

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Financial Policy

All co-payments are due at the time services are rendered.

As a condition of your treatment by this office, financial agreements must be made in advance. Our office accepts assignment of insurance benefits. We verify eligibility and coverage for all insurances: if your insurance is expected to pay a portion of your bill, we will wait for that portion from them. It is your responsibility to pay any co-pays, deductibles, or any amounts not expected from your insurance at the time treatment is provided. If your insurance company has not paid the full balance within 60 days, the balance of your account will become your responsibility. If you do not have insurance, or if our office does not accept assignment from your insurance company then payment is due in full at the time of treatment.

We are a third party administrator of your insurance carrier and are NOT responsible for how your insurance handles your claims or how benefits are assigned. We can assist in estimating the cost of your portion of treatment, but cannot be responsible for any changes in your insurance policy or benefits used elsewhere. It is your responsibility to let us know if there are any changes to your insurance, if your policy is terminated, or if you have used benefits elsewhere. Please remember that insurance is a contract between you and your insurance company, our office is not a part of this contract. You are responsible for the timely payment of your account.

Our office accepts cash, Visa, MasterCard, Discover, American Express, and Care Credit. We do not accept check payments.

In this office we believe in providing our patients with the utmost care. This means using the best materials available in order to promote and preserve a healthy smile. We understand that your dental insurance may downgrade to amalgam (metal) fillings, however this is a mercury free office, therefore the patient is responsible for any difference in cost.

X-rays and Photographs Policy

I authorize Woodlake Family Dental to take any x-rays and photographs deemed necessary for the detection and diagnoses of oral decay and disease. I authorize the release of this and any other information to my insurance company necessary to processing my dental claim in accordance with HIPPA regulations.

Cancellation Policy

If you find it impossible to keep an appointment, for consideration of other patient's needs, we ask for at least a 48 hour notice. Appointments cancelled or missed without a 48 hour notice are subject to a fee. We believe the dental appointment represents a shared responsibility for both the doctor and the patient, in order to have quality dental care at an affordable cost these appointments must be kept. If you fail to confirm your appointments, our office reserves the right to cancel your appointment or those of your family members. After two missed appointments, we will no longer be able to reserve appointment time for you in advance.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

Signature ____ Date: ____________________

WOODLAKE FAMILY DENTAL

Acknowledgement of Receipt of Notice of Privacy Practices

I ____, hereby acknowledge receipt of Woodlake Family Dental's Notice of Privacy Practices detailed information about how the office may use and disclose my confidential information.

Patient Name: ______________________________________

Relationship to patient: ________________________________

Signature ____ Date: ____________________

Request for Confidential Communications

Written Communications:

If the address provided on the first page is **not** your home address, please provide us with a street address for purposes of ensuring payment and appointment reminders.

____

The best way for Woodlake Family Dental's staff to contact me is by: (Circle one) Home # Cell # E-mail

Oral Communications:
May we leave a message at the numbers provided for the following?

Home # : Yes / No Cell # : Yes / No

May we leave a message that you need to pre-medicate? Yes / No

May we leave a message that you have a dental appointment? Yes / No

May we leave a message that you require a dental appointment? Yes / No