whc CELL PHONE:_____ E-MAIL:_____

CHART # _____

PATIENT INFORMATION

Patient's Name _____ (Last / First / MI)

Home Address _____ (# Street)

_____ (City / State / Zip)

Home Phone # _____ Work Phone # _____

Birthdate _____ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐

Social Security Number _____

Place of Employment:

Self _____ (Firm's Name / Date of Hire)

Spouse or Parent _____ (Firm's Name / Date of Hire)

Person responsible for account if other than self:

Name _____ Relation to Patient _____

Street _____ Phone # _____

City _____ State _____ Zip _____

Social Security # _____ Birthdate _____

DENTAL INSURANCE INFORMATION

Are you covered by Dental Insurance ☐ Yes ☐ No. If yes, please complete the following:

Primary Insurance Carrier _____

Contract # _____ Group # _____

Policy in name of _____

Policyholder's Birthdate _____

Secondary Insurance Carrier _____

Contract # _____ Group # _____

Policy in name of _____

Policyholder's Birthdate _____

DENTAL HISTORY

Please explain any Dental problems you are having _____

When did you last visit a Dentist _____ Treatment received _____

I have a: ☐ Full Denture - Date Made _____ ☐ Partial Denture - Date Made _____ ☐ Full set x-rays within last 3 years

Are you satisfied with the appearance of your teeth? Explain _____

Are your teeth sensitive to ☐ Hot ☐ Cold ☐ Sweet

How often do you brush your teeth _____ Have you ever had treatment for your gums? ☐ Yes ☐ No

Type of toothbrush ☐ Soft ☐ Medium ☐ Hard Do you use Dental Floss? ☐ Yes ☐ No

MEDICAL HISTORY

General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Physician's Name _____

Physician's Address/Phone # _____

Date of Last Physical Examination _____

Are you currently being treated for a medical condition? ☐ Yes ☐ No

Nature of condition _____

Have you had or do you have any of the following: (Please Check if Yes)

- ☐ Heart Murmur/Mitral Valve Prolapse
- ☐ Heart Problems/Rheumatic Fever/Pacemaker
- ☐ Blood Disorder/Anemia/Prolonged Bleeding
- ☐ Liver Disease/Hepatitis
- ☐ Asthma/Hay Fever/Sinus Problems
- ☐ Malignancy/Radiation Treatment/Chemotherapy
- ☐ Hospitalization in Past 5 Years
- ☐ High Blood Pressure/Low Blood Pressure
- ☐ Thyroid Disorder
- ☐ Psychiatric Care/Depression
- ☐ Diabetes
- ☐ Artificial Joint or Valves
- ☐ Epilepsy
- ☐ HIV+
- ☐ Chemical or Alcohol Dependency
- ☐ Kidney Disease
- ☐ Venereal Disease
- ☐ Herpes
- ☐ TMJ/Head & Neck Pain
- ☐ Digestive (Stomach or Intestinal) Disorders

If you have checked any of the above, please give more detail and approximate dates of illness: _____

Have you had an adverse reaction to or developed an allergy to any medication? ☐ Yes ☐ No

If yes, which medication: _____

Are you currently taking any medication? ☐ Yes ☐ No If yes, which kind: _____

If you are a woman, do you believe you may be pregnant? ☐ Yes ☐ No

In case of emergency notify _____ Relationship _____ Phone # _____

FOR OFFICE USE ONLY

Dates Med. History Reviewed

If my account becomes delinquent (I have a balance still due 60 days from date of service), I agree that I will be liable for all costs, interest and actual attorney's fees incurred (up to and including 50% of the balance due) in the collection of the balance. Interest will be added at 1.33% per month on any account due over thirty (30) days. I agree to a broken appointment charge of at least $40 for any appointment not cancelled at least 24 hours in advance. I understand that the broken appointment charge may be more based on the time and expertise necessary for the service to be rendered. I agree to a bad check fee of $50 for any returned check. I also give permission to the doctors to use anesthetics ("novocaine") and/or relaxants ("laughing gas") as needed to complete any dental case.

_____ _____ _____

Signature Date Relation to Patient