Woodlands Village
DENTISTRY

Who may we thank for referring you to our office? _____ Today's Date: _____

Patient Information

Patient Name:_____ Preferred Name:_____
Date of Birth:_____ SS#_____ Marital Status:_____ Gender: M / F
Address:_____ City:_____ State:_____ Zip:_____
Home Phone:_____ Cell:_____ Work:_____
Email:_____ Employer:_____ Occupation:_____
Employer Address:_____ Employer Phone:_____
Emergency Contact:_____ Relationship:_____ Phone:_____

Primary Insurance Information

Subscriber's Name:_____ Date of Birth:_____ Employer:_____
Insurance Company:_____ Phone:_____
SS/ID#:_____ Group#:_____

Secondary Insurance Information

Subscriber's Name:_____ Date of Birth:_____ Employer:_____
Insurance Company:_____ Phone:_____
SS/ID#:_____ Group#:_____

Would you like E-mail and text message reminders? Email Y / N Text Y / N

Dental History

What would you like us to do today?_____ Are you in dental discomfort? Y / N
Former Dentist:_____ Address:_____
Phone:_____ E-mail:_____
Date of last dental care:_____ Date of last x-rays:_____

Check yes or no if you have had problems with any of the following:

Y	N		Y	N		Y	N		Y	N	
		Bad breath			Food collection between teeth			Periodontal treatment			Sensitivity to sweets
		Bleeding gums			Grinding or clenching			Sensitivity to cold			Sensitivity when biting
		Popping jaw			Loose or broken teeth			Sensitivity to hot			Sores/growths in mouth

How often do you brush?_____ Floss?_____

How do you feel about the appearance of your teeth?_____

Medical History

Physician's name:_____ Phone:_____
Are you under a physician's care? Y / N Date of last visit:_____
Have you had any major operations? Y / N If yes, describe:_____
Have you had any serious illnesses? Y / N If yes, describe:_____
Have you ever had a blood transfusion? Y / N If yes, give approximate date:_____
Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel, and Boniva? Y / N
Women: Are you pregnant? Y / N Nursing? Y / N Taking birth control pills? Y / N

Check yes or no if you have had any of the following:

Y	N		Y	N		Y	N		Y	N	
		AIDS/HIV positive			Cortisone treatments			High blood pressure			Shortness of breath
		Anaphylaxis			Cough, persistent			Jaw pain			Skin rash
		Anemia			Cough up blood			Kidney disease			Spina Bifida
		Arthritis/Rheumatism			Diabetes			Liver disease			Stroke
		Artificial heart valves			Epilepsy			Material allergies (latex, metal, chemicals)			Surgical implant
		Artificial joints			Fainting			Mitral valve problems			Swelling of feet/ankles
		Asthma			Food allergies			Nervous problems			Thyroid disease/malfunction
		Atopic (allergy prone)			Glaucoma			Pacemaker/heart surgery			Tobacco habit
		Back problems			Headaches			Psychiatric care			Tonsillitis
		Blood disease			Heart murmur			Rapid weight loss/gain			Tuberculosis
		Cancer			Heart problems Describe:_____			Radiation Treatment			Ulcer/Colitis
		Chemical dependency			Hemophilia/Abnormal bleeding			Respiratory disease			Venereal disease
		Chemotherapy			Herpes			Rheumatic/Scarlet fever			Other
		Circulatory problems			Hepatitis			Shingles			

Is patient currently taking any medications? Y / N
If yes, please list: _____
_____

Does patient have any drug allergies? Y / N
If yes, please list:_____
_____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and helpful dental treatment. If there is any change in my medical status, I will inform the dentist.

Signature:_____ Date:_____