DATE: _____

PATIENT NAME: Last _____ *First* _____ *Nickname* _____

DATE OF BIRTH: _____ ☐ *FEMALE* ☐ *MALE* ☐ *MARRIED* ☐ *SINGLE* ☐ *CHILD* ☐ *OTHER* _____

ADDRESS: _____ *CITY, STATE, ZIP:* _____

PHONE: Home: _____ *Work:* _____ *Cell:* _____

EMAIL: _____ *PREFERRED CONTACT:* ☐ *EMAIL* ☐ *PHONE* ___ *Home* ___ *Cell* ___ *Work* ☐ *Text*

SOCIAL SECURITY NUMBER:(if we will be courtesy filing insurance on your behalf) _____

DRIVER'S LICENSE NUMBER: _____

EMERGENCY CONTACT:NAME: _____ *RELATIONSHIP TO YOU:* _____ *PHONE:* _____

EMERGENCY CONTACT: NAME: _____ *RELATIONSHIP TO YOU:* _____ *PHONE:* _____

INSURED OR RESPONSIBLE PARTY INFORMATION*:*

NAME: _____ *is insured an existing patient?* ☐ *YES* ☐ *NO Relationship to patient:* _____

DATE OF BIRTH _____ ☐ *FEMALE* ☐ *MALE SOCIAL SECURITY NUMBER:* _____

ADDRESS: _____ *CITY, STATE, ZIP:* _____

PHONE: Home _____ *Work* _____ *Cell* _____

*INSURED'S EMPLOYER NAME:*_____ *EMPLOYER PHONE:*_____

*OCCUPATION:*_____

*INSURANCE PLAN:*_____ *ID #* _____ *GROUP #* _____

*ADDRESS:*_____ *PHONE NUMBER:* _____ *Secondary Insurance*:☐Yes☐ No

AT WIMBERLEY DENTAL CENTER WE CONSIDER OURSELF TO BE A TOTAL WELLNESS PRACTICE. PROPER DENTAL CARE CAN HAVE A POSITIVE IMPACT ON OTHER DISEASE TREATMENTS OR CHRONIC ILLNESSES. WE PREFER TO WORK CLOSELY WITH OTHER HEALTH CARE PROVIDERS FOR YOUR SUCCESS. TO HELP OUR PATIENTS ACHIEVE TOTAL HEALTH IT IS IMPORTANT THAT WE HAVE A CLEAR VISION OF YOUR HEALTH HISTORY. PLEASE FILL IN THE FORM BELOW TO THE BEST OF YOUR ABILITY.

MEDICAL HISTORY

NAME OF PHYSICIAN/S AND/OR SPECIALIST YOU SEE: _____

_____

MOST RECENT PHYSICAL EXAMINATION DATE: _____ PURPOSE: _____

HOW WOULD YOU DESCRIBE YOUR PRESENT HEALTH: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

HAVE YOU EVER BEEN HOSPITALIZED FOR AN ILLNESS OR INJURY? ☐ NO ☐ YES _____

LIST SURGICAL HISTORY AND DATES ALONG WITH ANY IMPENDING SURGERY: _____

_____

_____

KNOWN ALLERGY OR ALLERGIC REACTION TO:

☐ ASPIRIN	☐ CODEINE
☐ TYLENOL	☐ LATEX
☐ IBUPROFEN	☐ METALS
☐ PENICILLIN	☐ FLUORIDE
☐ ERYTHROMYCIN	☐ ADHESIVES
☐ TETRACYCLINE	☐ LOCAL ANESTHETIC
☐ SULFA	☐ OTHER

DO YOU HAVE A CURRENT OR PREVIOUS DIAGNOSIS OF:

☐ ANEMIA	☐ OSTEOPENIA/OSTEOPOROSIS
☐ ANGINA	☐ BISPHOSPHONATE USE
☐ ARTIFICIAL HEART VALVE: TYPE	☐ HIVES/ECZEMA/SKIN RASH
☐ BLEEDING DISORDER	☐ GLAUCOMA
☐ BLOOD DISORDER/S	☐ CONTACT LENSES/GLASSES
☐ PROLONGED BLEEDING	☐ TMJ DISORDER
☐ SICKLE CELL	☐ GRINDING OR CLENCHING OF TEETH
☐ HEART PROBLEMS	☐ DIZZINESS
☐ HYPERTENSION/HIGH BLOOD PRESSURE	☐ EPILEPSY/SEIZURES
☐ HYPOTENSION/LOW BLOOD PRESSURE	☐ FAINTING
☐ HIGH CHOLESTEROL OR TAKING STATINS	☐ HEAD OR NECK INJURY/HISTORY OF: DATE
☐ HIGH TRIGLYCERIDES	☐ PSYCHIATRIC DISORDER/S: LIST
☐ PACEMAKER/DEFIBRILLATOR: PLACED	☐ ANOREXIA/BULIMIA
☐ STROKE: DATE	☐ ANXIETY: INCREASED BY
☐ TIA: DATE	☐ DEPRESSION
☐ HEART DISEASE	☐ OFTEN FATIGUED OR TIRED
☐ ABNORMAL HEART RHYTHYM: LIST	☐ CONSIDERED A TOUCHY PERSON
☐ HEART ATTACK/MI: DATE	☐ NEUROLOGIC DISORDER: SPECIFY
☐ STENT PLACEMENT: DATE	☐ NEURALGIA/S
☐ RHEUMATIC/SCARLET FEVER: DATE	☐ EMOTIONAL DIFFICULTIES: SPECIFY
☐ SWELLING OF FEET/HANDS/CIRCULATORY DISORDER	☐ ADD/ADHD/HYPERACTIVITY
☐ REPAIRED HEART DEFECT: DATE	☐ DIABETES: TYPE: HgA1C:
☐ DIGESTIVE DISORDER/S: LIST	☐ DIALYSIS: DAYS
☐ GERD	☐ HYPOTHYROIDISM/LOW THYROID
☐ ACID REFLUX	☐ HYPERTHYROIDISM/HIGH THYROID
☐ LUMPS OR SWELLING IN THE THROAT	☐ HORMONE DEFICIENCY: TYPE
☐ DIFFICULTY SWALLOWING	☐ THYROID, PARATHYROID, OR CALCIUM DEFICIENCY
☐ SENSITIVE GAG REFLEX	☐ ASTHMA/RAD
☐ STOMACH/DUODENAL ULCER/S	☐ CHRONIC BRONCHITIS
☐ ARTHRITIS/GENERALIZED ACHES	☐ CHRONIC COUGH
☐ AUTOIMMUNE DISEASE: TYPE	☐ COPD
☐ FIBROMYALGIA	☐ EMPHYSEMA
☐ ARTIFICIAL JOINTS/ORTHOPEDIC IMPLANTS	☐ OXYGEN THERAPY: RUNNING AT: LPM

☐ SINUS PROBLEMS	☐ CONGENITAL DEFECT/S: LIST
☐ BREATHING/SLEEP DISORDER: TYPE	☐ DIFFICULTY HEARING
☐ USE OF CPAP MACHINE	☐ ORAL REMOVABLE DEVICE: TYPE
☐ SEASONAL ALLERGIES: LIST	☐ KIDNEY DISEASE/STAGE:
☐ SNORING	☐ HISTORY OF TRANSPLANT: TYPE/DATE
☐ SHORTNESS OF BREATH	☐ CANCER: TYPE/DATE
☐ TUBERCULOSIS	☐ CYST OR ABNORMAL GROWTH
☐ LIVER DISEASE	☐ RADIATION THERAPY: DATE
☐ HEPATITIS: TYPE	☐ CHEMOTHERAPY/IMMUNOSUPRESSIVE MEDICATION
☐ HIV/AIDS	☐ HISTORY/CURRENT RECREATIONAL DRUG USE/ABUSE
☐ JAUNDICE	☐ HISTORY/CURRENT UES OF SEDATIVES/TRANQUILIZERS
☐ STD/HPV: LIST	☐ HISTORY OR CURRENT BOTOX/COLLAGEN INJECTIONS
☐ VIRAL INFECTIONS OR COLD SORES	☐ HISTORY OR CURRENT USE OF ASPIRIN
☐ DELAYED HEALING TIME	☐ USE OF HERBAL SUPPLEMENTS
☐ CLEFT LIP/PALATE	☐ TAKING MEDICATION FOR WEIGHT LOSS

☐ ADDITIONAL HEALTH HISTORY: _____

FEMALES:

ARE YOU CURRENTLY PREGNANT OR PLANNING TO BECOME PREGNANT? ☐ NO ☐ YES DUE DATE: _____

ARE YOU CURRENTLY BREASTFEEDING? ☐ NO ☐ YES DO YOU USE ORAL CONTRACEPTIVES? ☐ NO ☐ YES

MEN:

CURRENT/HISTORY OF PROSTATE DISORDER? ☐ NO ☐ YES _____

DO YOU USE TOBACCO? ☐ NO ☐ YES TYPE:_____HOW MUCH/HOW OFTEN:_____QUIT: _____

DO YOUR CONSUME ALCOHOL? ☐ NO ☐ YES TYPE:_____HOW MANY DRINKS PER DAY:_____QUIT: _____

MEDICATION LIST

LIST ALL MEDICATIONS, SUPPLEMENTS, AND OR VITAMINS TAKEN WITH IN THE LAST TWO YEARS. IF YOU HAVE A WRITTEN COPY WE WILL BE MORE THAN HAPPY TO MAKE A COPY FOR YOUR RECORD. KNOW THE IMPORTANCE OF LISTING ALL MEDICATIONS USED. WE MUST AVOID ANY POSSIBLE DRUG INTERACTIONS THAT MAY ARISE FROM ROUTINELY USED DENTAL TREATMENT.

☐ USE OF DAILY BLOOD THINNER/S: _____

MEDICATION	MEDICATION	MEDICATION

PREFERRED PHARMACY NAME:_____ PHONE NUMBER: _____

KNOW THAT IT IS WITHIN OUR STANDARD OF CARE TO COMPLETELY UPDATE YOUR HEALTH HISTORY YEARLY. IF YOU HAVE HAD A RECENT UNDOCUMENTED CHANGE IN YOUR MEDICAL HISTORY OR MEDICATION BETWEEN VISITS, PLEASE ADVISE THE OFFICE IMMEDIATELY.

DENTAL HEALTH HISTORY

WHO MAY WE THANK FOR REFERRING YOU: _____

HOW WOULD YOU RATE YOUR DENTAL HEALTH: ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

PREVIOUS DENTIST: _____HOW LONG WERE YOU A PATIENT: _____

DATE OF MOST RECENT DENTAL EXAM: _____ DATE OF MOST RECENT X-RAYS: _____

I ROUTINELY SEE MY DENTIST EVERY: ☐ 3 MONTHS ☐ 6 MONTHS ☐ 12 MONTHS ☐ NOT ROUTINELY

HOW OFTEN DO YOU BRUSH: _____ DO YOU USE AN ELECTRIC TOOTHBRUSH? ☐ NO ☐ YES BRAND _____

DO YOU USE FLUORIDE TOOTHPASTE: ☐ NO ☐ YES HOW OFTEN DO YOU FLOSS: _____

WHAT TYPE OF WATER DO YOU HAVE AT HOME: ☐ WELL ☐ TAP ☐ BOTTLED ☐ OTHER _____

DO YOU CONSUME SUGARY FOODS AND OR BEVERAGES ON A REGULAR BASIS? ☐ NO ☐ YES

WHAT FOOD/DRINK DO YOU CONSUME REGULARLY: _____HOW OFTEN: _____

ARE YOU EXPERIENCING ANY DISCOMFORT AT THIS TIME? ☐ NO ☐ YES

WHAT IS YOUR IMMEDIATE CONCERN? _____

PERSONAL DENTAL HISTORY		
Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most):_____	☐ NO	☐ YES
Have you had an unpleasant dental experience?	☐ NO	☐ YES
Have you ever had complications from past dental treatment?	☐ NO	☐ YES
Have you ever had trouble getting numb or a reaction to local anesthesia?	☐ NO	☐ YES
Have you ever had braces, orthodontic treatment, or your bite adjusted?	☐ NO	☐ YES
Have you ever had any teeth removed or have missing teeth that never developed?	☐ NO	☐ YES
Have you had any prolonged bleeding following extractions?	☐ NO	☐ YES
Do you wear dentures or partials?	☐ NO	☐ YES
Do you consider yourself cavity prone?	☐ NO	☐ YES

I AM MOST COMFORTABLE DURING MY DENTAL APPOINTMENTS WHEN:

_____

SMILE CHARACTERISTICS		
Have you ever whitened or bleached your teeth?	☐ NO	☐ YES
Have you ever been disappointed by the appearance of any previous dental work?	☐ NO	☐ YES
Are you self-conscious about your teeth?	☐ NO	☐ YES
Are your teeth in alignment (straight)?	☐ NO	☐ YES
Do you like the color of your teeth?	☐ NO	☐ YES
Do you like the shape of your teeth?	☐ NO	☐ YES
Are there old fillings or dental work you don't like looking at?	☐ NO	☐ YES

IF YOU COULD CHANGE ANYTHING ABOUT THE APPEARANCE OF YOUR TEETH WHAT WOULD IT BE:

_____

GUM AND BONE HISTORY		
Do your gums bleed or are they painful when brushing or flossing?	☐ NO	☐ YES
Have you ever been treated for gum disease?	☐ NO	☐ YES
Have you ever experienced any gum recession or exposed root surface?	☐ NO	☐ YES
Have you experienced a burning sensation in/around your mouth or tongue unrelated to teeth?	☐ NO	☐ YES
Have you ever been diagnosed with periodontal disease?	☐ NO	☐ YES
Is there anyone in your family that has been diagnosed with periodontal disease?	☐ NO	☐ YES
Have you ever been told you are losing bone around your teeth?	☐ NO	☐ YES
Are your teeth becoming loose on their own without a traumatic accident?	☐ NO	☐ YES
Have you ever noticed an unpleasant taste or odor in your mouth?	☐ NO	☐ YES
Do you frequently get blisters on the lips or mouth?	☐ NO	☐ YES
Do you bite your lips or cheeks frequently?	☐ NO	☐ YES

TOOTH STRUCTURE		
Have you had any cavities within the past 5 years?	☐ NO	☐ YES
Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	☐ NO	☐ YES
Do you have broken teeth, chipped teeth, or had a toothache or cracked filling?	☐ NO	☐ YES
Do you avoid chewing on one side of your mouth?	☐ NO	☐ YES
Do you notice any holes, grooves or notches in your teeth?	☐ NO	☐ YES
Do you frequently get food caught between any teeth?	☐ NO	☐ YES
Do you experience dry mouth?	☐ NO	☐ YES
When you swallow, does it feel like you have a lump in your throat?	☐ NO	☐ YES

BITE STRUCTURE		
Do you have problems with your jaw joint? (pain, sounds, limited opening, locking or popping)	☐ NO	☐ YES
Do you feel your lower jaw is being pushed back when you bite your teeth together?	☐ NO	☐ YES
Do you avoid or have difficulty chewing gum, carrots, nuts, bagels or other hard, dry food?	☐ NO	☐ YES
Have your teeth changed in the last 5 years, become shorter, thinner or worn?	☐ NO	☐ YES
Are your teeth becoming more crooked, crowded or overlapped?	☐ NO	☐ YES
Are your teeth developing spaces?	☐ NO	☐ YES
Do you have more than one bite or squeeze/shift your jaw to make your teeth fit together?	☐ NO	☐ YES
Do you place your tongue between your teeth or close your teeth against your tongue?	☐ NO	☐ YES
Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐ NO	☐ YES
Do you clench your teeth in the daytime or make them sore?	☐ NO	☐ YES
Do you grind your teeth?	☐ NO	☐ YES
Do you have frequent tension headaches ?	☐ NO	☐ YES
Do you wear or have you been told you need to wear a bite appliance?	☐ NO	☐ YES

I consent to dental and oral surgical procedures deemed necessary or advisable, including the use of local anesthetic, diagnostic/photographic and therapeutic procedures as may be necessary for proper dental care. I will assume responsibility of fees associated with these procedures. To the best of my knowledge, all of the information I have provided is correct. I commit to informing the doctor of any changes to mine or my minor child's health. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health care professionals as is beneficial for payment or dental care.

_____ _____

PATIENT'S PRINTED NAME TODAY'S DATE

_____ _____

PATIENT/GUARDIAN SIGNATURE DOCTOR'S SIGNATURE