WATERS
FAMILY DENTISTRY

Today's Date	

First Name		Last Name		Middle Initial	
Patient is ☐Policy Holder ☐Responsible Party		Preferred Name			
How did you hear about our office?					

Patient Information

Birth Date		Social Security Number			
Address					
City		State		Zip Code	
Home Phone		Cell Phone			
Email Address		Employer / Occupation			

Select contact preferences (check all that apply) ☐ Text ☐ Email ☐ Phone – Home ☐ Phone – Work

Sex ☐ Male ☐ Female Marital status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

If married, Spouse's name		Spouse's phone number

Emergency Contact (other than spouse)

Name_____

Relationship _____

Phone Number _____

Responsible Party (if someone other than the patient)

First Name		Last Name		Middle Initial	
Address					
City		State		Zip Code	
Home Phone		Cell Phone		Work Phone	
Birth Date		Social Security Number		Employer	

Responsible Party is also a Policy Holder for Patient ☐Primary Insurance Holder ☐ Secondary Insurance Holder

Insurance Information (If applicable)

Primary Insurance Name of Insured		Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other			
Insured Social Security		Employer		Insured Birth Date	
Secondary Insurance Name of Insured		Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other			
Insured Social Security		Employer		Insured Birth Date	

Dental History

Name of Previous Dentist		Are you happy with the shape of your teeth? ☐ Yes ☐ No
Date of Last Dental Visit		Are you happy with the color of your teeth? ☐ Yes ☐ No
How often do you brush?		Brush Type (please circle) Manual Mechanical
How often do you floss?		

Have you had Orthodontic Treatment? (Braces) ☐ Yes ☐ No

Have you had Periodontal Treatment? (Gum Disease) ☐ Yes ☐ No

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems you may have or medication you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering these questions.

Are you under a physician's care now? ☐ Yes ☐ No If yes, describe

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes,, describe

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, describe

Are you taking any medications, pills or drugs? ☐ Yes ☐ No If yes, describe

Have you ever taken Fosamax, Boniva, Actonel or any other medication containing bisphosphonates? ☐ Yes ☐ No If yes, describe

Are you on a special diet? ☐ Yes ☐ No If yes, describe

Do you use tobacco? ☐ Yes ☐ No If yes, describe

Do you use controlled substances? ☐ Yes ☐ No If yes, describe

Women: Are you ?

☐ Pregnant / Trying to Get Pregnant ☐ Nursing ☐ Taking Oral Contraceptives

Are you allergic to any of the following? ☐ No Known Allergies

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Do you have or have you had any of the following?

AIDS/HIV Positive ☐ Yes ☐ No	Cortisone Medicine ☐ Yes ☐ No	Hepatitis A ☐ Yes ☐ No	Recent Weight Loss ☐ Yes ☐ No
Alzheimers disease ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No	Hepatitis B or C ☐ Yes ☐ No	Renal Dialysis ☐ Yes ☐ No
Anaphylaxis ☐ Yes ☐ No	Drug Addiction ☐ Yes ☐ No	Herpes ☐ Yes ☐ No	Rheumatic Fever ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Easily Winded ☐ Yes ☐ No	High Blood Pressure ☐ Yes ☐ No	Rheumatism ☐ Yes ☐ No
Angina ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	High Cholesterol ☐ Yes ☐ No	Scarlet Fever ☐ Yes ☐ No
Arthritis/Gout ☐ Yes ☐ No	Epilepsy or Seizures ☐ Yes ☐ No	Hives or Rash ☐ Yes ☐ No	Shingles ☐ Yes ☐ No
Artificial Heart Valve ☐ Yes ☐ No	Excessive Bleeding ☐ Yes ☐ No	Hypoglycemia ☐ Yes ☐ No	Sickle Cell Disease ☐ Yes ☐ No
Artificial Joint ☐ Yes ☐ No	Excessive Thirst ☐ Yes ☐ No	Irregular Heartbeat ☐ Yes ☐ No	Sinus Trouble ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Fainting Spells ☐ Yes ☐ No	Kidney Problems ☐ Yes ☐ No	Spina Bifida ☐ Yes ☐ No
Blood Disease ☐ Yes ☐ No	Frequent Cough ☐ Yes ☐ No	Leukemia ☐ Yes ☐ No	Stomach Disease ☐ Yes ☐ No
Blood Transfusion ☐ Yes ☐ No	Frequent Diarrhea ☐ Yes ☐ No	Liver Disease ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Breathing Problems ☐ Yes ☐ No	Frequent Headaches ☐ Yes ☐ No	Low Blood Pressure ☐ Yes ☐ No	Swelling of Limbs ☐ Yes ☐ No
Bruise Easily ☐ Yes ☐ No	Genital Herpes ☐ Yes ☐ No	Lung Disease ☐ Yes ☐ No	Thyroid Disease ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Mitral Valve Prolapse ☐ Yes ☐ No	Tonsillitis ☐ Yes ☐ No
Chemotherapy ☐ Yes ☐ No	Hay Fever ☐ Yes ☐ No	Osteoporosis ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No
Chest Pains ☐ Yes ☐ No	Heart Attack/Failure ☐ Yes ☐ No	Pain in Jaw Joints ☐ Yes ☐ No	Tumors or Growths ☐ Yes ☐ No
Cold Sores ☐ Yes ☐ No	Heart Murmur ☐ Yes ☐ No	Parathyroid Disease ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No
Congenital Heart Disorder ☐ Yes ☐ No	Heart Pacemaker ☐ Yes ☐ No	Psychiatric Care ☐ Yes ☐ No	Venereal Disease ☐ Yes ☐ No
Convulsions ☐ Yes ☐ No	Heart Trouble ☐ Yes ☐ No	Radiation Treatment ☐ Yes ☐ No	Yellow Jaundice ☐ Yes ☐ No
	Hemophilia ☐ Yes ☐ No		

Have you ever had any serious illness not listed above ? ☐ Yes ☐ No If yes

Comments

Authorization Signature

I understand that the information I have given today is correct to the best of my knowledge, I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____ _____

Signature of Patient or Patient Representative **Date**

_____

Relationship to Patient if not signed by patient