WYTHE FAMILY DENTISTRY

PATIENT INFORMATION - *Please Print*

Patient's Name ____________________

First M.I. Last

Date of Birth ____________ Age ______ SSN ____________

Mailing Address ____________ Physical Address ____________

City ____________ County ____________ State ______ Zip ______

Home Phone ____________ Work Phone ____________ Cell Phone ____________

Email Address ____________________

Emergency Contact ____________ Phone Number ____________

ACCOUNT INFO

Who will be responsible for this account? ____________________

Name of Employer ____________________

If Minor: Mother's Name ____________ SSN ____________

Mailing Address ____________________

Name of Employer ____________ Work Number ____________

Father's Name ____________ SSN ____________

Mailing Address ____________________

Name of Employer ____________ Work Number ____________

If Applicable: Spouse's Name ____________ SSN ____________

Name of Employer ____________ Work Number ____________

Primary Insurance: Name of Dental Insurance ____________ Name of Employer ____________

Name of Insured ____________ DOB ______ ID# ______

Secondary Insurance: Name of Dental Insurance ____________ Name of Employer ____________

Name of Insured ____________ DOB ______ ID# ______

MEDICAL HISTORY

PLEASE ANSWER EACH OF THE FOLLOWING QUESTIONS.

In the following questions, check yes or no, whichever applies.

1. Are you in good health? ☐ Yes ☐ No
2. Have you been a patient in a hospital during the past two years? ☐ Yes ☐ No
3. Have you been under a physician's care during the past two years? ☐ Yes ☐ No
4. The name and address of your physician is ____________________

____

5. Check any of the following which you have had:

☐ anemia	☐ jaundice	☐ heart murmur	☐ cardiac pacemaker	☐ epilepsy
☐ asthma	☐ arthritis	☐ sinus trouble	☐ high blood pressure	☐ tuberculosis
☐ cough	☐ diabetes	☐ heart trouble	☐ psychiatric treatment	☐ cancer treatment
☐ stroke	☐ hepatitis	☐ rheumatic fever	☐ congenital heart lesions	☐ HIV

6. Have you had any other serious illness or operation? ☐ Yes ☐ No

If so, please explain: ____________________

Have you had a joint replaced? ☐ Yes ☐ No

If so, when? ____________________

7. Are you presently taking any medicine or drug (tablet or liquid)? ☐ Yes ☐ No

If so, please list: ____________________

8. Are you taking any of the following?

A. Antibiotics or sulfa drugs ☐ Yes ☐ No

B. Anticoagulants (blood thinners) ☐ Yes ☐ No

C. Medicine for high blood pressure ☐ Yes ☐ No

D. Cortisone (steroids) ☐ Yes ☐ No

E. Tranquilizers ☐ Yes ☐ No

F. Antihistamines ☐ Yes ☐ No

G. Insulin, tolbutamide (Orinase) or similar drug ☐ Yes ☐ No

H. Digitalis or drugs for heart trouble ☐ Yes ☐ No

I. Aspirin ☐ Yes ☐ No

J. Nitroglycerin ☐ Yes ☐ No

K. Oral contraceptive or other hormonal therapy ☐ Yes ☐ No

L. Other: ____________________

9. Are you allergic or have you reacted adversely to any of the following:

A. Local anesthetics ☐ Yes ☐ No

B. Penicillin or other antibiotics ☐ Yes ☐ No

C. Sulfa drugs ☐ Yes ☐ No

D. Barbiturates, sedatives, or sleeping pills ☐ Yes ☐ No

E. Aspirin ☐ Yes ☐ No

F. Iodine ☐ Yes ☐ No

G. Codeine ☐ Yes ☐ No

H. Other: ____________________

10. Do you have any disease, condition, or problem not listed above? ☐ Yes ☐ No

FOR WOMEN

11. Are you pregnant? ☐ Yes ☐ No

12. Are you nursing? ☐ Yes ☐ No

DENTAL HISTORY

13. Do you like the appearance of your teeth? ☐ Yes ☐ No

14. Are you satisfied with your smile? ☐ Yes ☐ No

15. Have you had abnormal bleeding associated with previous extraction, surgery, or trauma? ☐ Yes ☐ No

16. Date of last dental visit ____________________. Brief explanation of treatment rendered:

____

17. Do your gums bleed when you brush or floss? ☐ Yes ☐ No

18. Have you had any serious trouble associated with previous dental treatment? ☐ Yes ☐ No

If so, please explain: ____________________

____________________ ____________________

Signature *(Patient or Parent if Minor)* **Date**