WESTBERRY FAMILY DENTISTRY

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PATIENT INFORMATION

Date_____

NAME_____ PLEASE CIRCLE ONE: MR. MRS. MS. MISS. DR.

PLEASE CIRCLE ONE: MARRIED SINGLE CHILD DIVORCED OTHER_____

ADDRESS _____ CITY _____ STATE ____ ZIP_____

HOME #_____ WORK # _____ MOBILE # _____EMAIL _____

SOCIAL SECURITY # _____ DRIVER'S LICENSE # _____ DATE OF BIRTH _____

EMPLOYER _____

EMPLOYER'S ADDRESS _____ CITY _____ STATE ____ ZIP _____

SPOUSE/PARENT NAME _____

WHOM MAY WE THANK FOR REFERING YOU? _____

DENTAL INSURANCE INFORMATION

SUBSCRIBER'S NAME_____ RELATIONSHIP TO PATIENT _____

DATE OF BIRTH _____ SUBSCRIBER'S SOCIAL SECURITY NUMBER _____

NAME OF EMPLOYER _____ PHONE NUMBER _____

INSURANCE COMPANY _____ PHONE NUMBER _____

INSURANCE COMPANY'S ADDRESS _____CITY _____ STATE ____ ZIP _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ MAX ANNUAL BENEFIT _____

DENTAL HISTORY

ARE YOU CONCERNED ABOUT OR EXPERIENCING ANY OF THE FOLLOWING?

☐ Sensitivity To Sweets	☐ Grinding/Clenching Your Teeth	☐ Dry Mouth
☐ Sensitivity To Hot/Cold	☐ Food Trapping Between Teeth	☐ Clicking/Pain in Jaw Joints
☐ Staining of Your Teeth	☐ Discolored Fillings	☐ Roughness of Existing Fillings
☐ Bleeding Gums	☐ Bad Breath	☐ Sensitivity When Eating
☐ Missing Teeth	☐ Ability To Eat	☐ Gaps Between Your Teeth
☐ Crooked Teeth	☐ Your Smile	☐ Existing Crowns, Bridges, Dentures

PATIENTS NAME _____

MEDICAL HISTORY

PRIMARY CARE PHYSICIANS NAME _____ PHONE NUMBER _____

ARE YOU CURRENTLY SEEING A SPECIALIST? (PLEASE CIRCLE ONE) **YES** **NO**

IF YES, PLEASE LIST THE NAMES OF ALL SPECIALISTS YOU ARE SEEING

_____

_____

_____

PLEASE LIST ANY MEDICATIONS THAT YOU ARE CURRENTLY TAKING

_____

_____

_____

PLEASE LIST ANY ALLERGIES TO MEDICATIONS OR SUBSTANCES

_____

_____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? (PLEASE CIRCLE "YES" OR "NO")

A.I.D.S./H.I.V. POSITIVE…….....YES NO
ARTIFICIAL HEART VALVE…….....YES NO
ARTIFICIAL JOINTS……..……...YES NO WHAT TYPE?_____ WHEN?_____
ASTHMA…….…...…YES NO
CANCER…….…….....YES NO WHAT TYPE? _____ WHEN? _____
CHEMOTHERAPY……....YES NO
DIABETES……..…….....YES NO
DRUG DEPENDANCY……YES NO
EPILEPSY/SEIZURES……...YES NO
EXESSIVE BLEEDING…….…..YES NO
HEART(**CIRCLE ONE:** ATTACK, DISEASE, SURGERY)...…YES NO IF YES, WHEN?_____
HEPATITIS (CIRCLE AKK THAT APPLY: A, B, C)…..…YES NO
HIGH BLOOD PRESSURE……YES NO
KIDNEY DISEASE……..YES NO
LATEX ALLERGY……..YES NO
LIVER DISEASE……..YES NO
OSTEOPOROSIS……...…..YES NO
HAVE YOU EVER HAD OR EVER TAKEN
MEDICINE FOR OSTEOPOROSIS?.....YES NO
STROKE…….…...…YES NO
TOBACCO USE…….……..YES NO
TUBERCULOSIS……...…..YES NO

WOMEN

ARE YOU**: PREGNANT?** YES ___ MONTHS NO **NURSING?** YES NO **TAKING BIRTH CONTROL** YES NO

PLEASE LIST ANY DISEASE OR CONDITION THAT YOU HAVE OR HAVE HAD THAT MAY NOT BE LISTED ABOVE: _____

X_____ **DATE** _____

SIGNATURE OF PATIENT (OR PARENT/GUARDIAN IF PATIENT IS A MINOR)