

# Wall Family Dentistry

Welcome to our office. You're going to love it here!

This information is for use of the dental office and is regarded as confidential

<p><b>Patient's name and responsible party</b> Credit history may be reviewed for those requesting credit payment. Date: _____</p> <p>Name: _____ Address: _____ City: _____ State: _____ Zip: _____ How long at present address: 0-2 yr. _____ 2-5 years _____ 5+ _____ Home Phone: _____ Cell: _____ e-mail address: _____ Social Security number: _____ Birthdate: _____ Driver's license state/number: _____ Occupation: _____ Employer: _____ Business address: _____ Business phone: _____ ext.: _____ Name of spouse: _____ Occupation: _____ Employer: _____ Business phone: _____ Cell: _____</p> <p>If a dependent: School attending: _____ Grade: _____</p> <p>Person responsible for account( if different from above): _____ Address: _____ City: _____ State: _____ Zip: _____ Home Phone: _____ Cell: _____</p> <p>Emergency contact-name: _____ Home Phone: _____ Cell phone: _____ Closest living relative not living with you: _____ Address: _____ Phone Number: _____ Cell #: _____</p>	<p><b>Insurance Information</b></p> <p>Primary Carrier Insurance Co: _____ Name on Insurance: _____ Policy #: _____ Effective date: _____</p> <p>Secondary Carrier Insurance Co: _____ Name on Insurance: _____ Policy #: _____ Effective date: _____</p> <p><b>Getting to Know You</b></p> <p>Is another member of you family or relative a patient at our office? _____</p> <p>Who referred you to us: _____</p> <p>Is there anything cosmetically or functionally that you would like to change about your smile: _____ _____ _____</p> <p>Thanks for coming to see us today. Our Goal is to combine oral health and aesthetics to give our patients the smile of their dreams. Let us exceed your expectations.</p>
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Reason for dental visit: \_\_\_\_\_

How long has it been since your last dental exam? \_\_\_\_\_

Are you pleased with the appearance of your teeth? \_\_\_\_\_

Are you familiar with the term preventative dentistry? \_\_\_\_\_

Do you feel you have had good dental care in the past? \_\_\_\_\_

Do you use dental floss? \_\_\_\_\_ Do you brush your teeth at least twice a day? \_\_\_\_\_

Have you ever had orthodontic treatment? \_\_\_\_\_

Are any of your teeth sensitive to hot, cold, sweets or to bite on (where) \_\_\_\_\_

Do you have a purplish rash or persistent purplish bruise(s)? \_\_\_\_\_

Have you lost any teeth? And which ones? \_\_\_\_\_ Were teeth replaced? \_\_\_\_\_

Have you ever had any problems with tooth extractions?  
\_\_\_\_\_

Do you have problems with food wedging between your teeth? \_\_\_\_\_

If you have dentures, how long have you had them? \_\_\_\_\_

Do you have frequent bad breath or unpleasant taste in your mouth? \_\_\_\_\_

Do you grind or clinch your teeth? \_\_\_\_\_ Have you worn a night guard? \_\_\_\_\_

Are you apprehensive about dental treatment? \_\_\_\_\_

Would you like to know procedures used to help control pain, fear, and anxiety? \_\_\_\_\_

Have you ever had excessive bleeding requiring special treatment? \_\_\_\_\_

Have you ever had blood tests for AIDS or Hepatitis? \_\_\_\_\_

Have you had any serious illness? \_\_\_\_\_

Have you ever worked in a hospital, institution, microbiological or testing laboratory? \_\_\_\_\_

**Patient or responsible party, please answer these confidential questions.**

Are you currently under treatment by physician? \_\_\_\_\_ Name of Physician: \_\_\_\_\_  
 Physician's address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 What are you seeing the physician for? \_\_\_\_\_  
 Other physicians being seen and for what? \_\_\_\_\_

Date of last physical: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Names of drugs or medications currently being taken: \_\_\_\_\_

Do you have or have had, or been advised by a physician for any of the following?

	How long or When	Yes	No		How long or When	Yes	No
Aids				Liver or kidney Disease			
Arthritis				Lung Disorders			
Artificial heart valves				Persistent Diarrhea			
Blood Disorder/Anemia				Joint replacement/ prosthetic			
Cancer TX				Psychiatric treatment			
Cardiac Pacemaker				Radiation treatment			
Chronic Cough				Tuberculosis			
Congenital heart lesions				Rheumatic Fever			
Constant night sweats				Shortness of breath			
Diabetes				Sinus trouble			
Epilepsy or convulsions				Stomach/ digestive problems			
Fainting				Stroke			
Frequent headache				Swelling of ankles			
Heart disease				Thyroid disease			
Heart Murmur				Hyperthyroidism			
Hepatitis A B C				Tumor History			
High blood pressure				Unusual weightloss			
Hospitalized in the last 3 years				Do you smoke?			
Kidney Treatment				Are you pregnant?	How many months?		

Do you have any **allergies** to:

	Yes	No		Yes	No		Yes	No		Yes	No
Penicillin			Other antibiotics			Codeine/Aspirin			Local Anesthetic		

Allergies/ Reactions to other medication:

Any other allergies:

Do you have any of the following in/on your mouth, tongue, lips, or neck?

	Yes	No		Yes	No		Yes	No		Yes	No
New swelling in mouth/neck			Swollen, purplish gums			Cold sores/cancer sores			Grey-white growth or rash on cheek or neck		

If you answered yes to any of the above: please explain: \_\_\_\_\_

Please add any other dental information that you may think will aid us in treating you: \_\_\_\_\_

I certify that the statements in this disclosure are true, accurate, and complete to the best of my knowledge.

**Consent:** The undersigned hereby authorizes the doctor or Wall Family Dentistry to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a through diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment including medication and or therapy that may be indicated in connection with (Name of Patient) \_\_\_\_\_, and further authorize and consent that the Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agent embodies certain risks. I understand that responsibility for payment for dental services provided in this office for myself and my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made in writing. I also understand that after 60 days there will be a finance charge on any unpaid balance. If my account becomes delinquent and goes to collections, I will be responsible for all attorney and collection fees incurred. I understand that appointments are given on a reserved basis and agree to give 24- hour notice for an appointment change. For those dealing with credit, a credit history will be required. I authorize the use of my testimonials, and before and after pictures to be used in marketing and/or for educational purposes. I understand that my full name will not be used in these instances.

Signature: \_\_\_\_\_ Name: \_\_\_\_\_

Relationship to dependent: \_\_\_\_\_ Date: \_\_\_\_\_