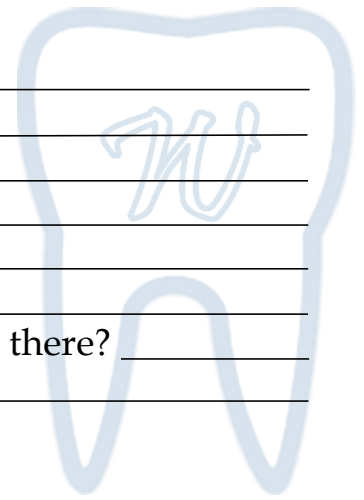


Welcome to Wood Dental Group!

GENERAL INFORMATION:

Name: _____ Today's Date: _____
Birthdate: _____ Age: _____ Social Security #: _____
Address: _____ Email Address: _____
City: _____ State: _____ Zip Code: _____
How long have you lived there? _____ Home Phone: _____
Cell Phone: _____ Work Phone: _____
Employer: _____ How long have you worked there? _____
Employer Address: _____
Status: Single Divorced Minor
 Married Separated Widowed
Spouse's Name: _____
Do you have children? Yes If so, how many? _____
 No



REFERRAL INFORMATION:

How did you hear about us?

- From another patient: _____ Facebook or website
 From a staff member: _____ From an advertisement _____
 Other: _____

DENTAL HISTORY

Previous Dentist: _____ Date of last dental exam: _____
Have you had dental X-rays in the last year? Yes No
Are you nervous about dental treatment? Yes No
How many times a day do you brush? _____ Floss? _____
What type of toothbrush bristles do you use? Soft Medium Hard
How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best)

TODAY'S VISIT

Reason for today's visit: Exam Emergency Consultation

Are you in pain? Yes No If yes, for how long? _____

Please check the box if you currently have any of the following conditions:

- Discomfort, clicking, or popping of jaws Lost/broken filling(s) Locking jaw
 Blisters/sores in or around mouth Bad breath Teeth grinding
 Red, swollen, or bleeding gums Ringing in ears Stained teeth
 Sensitive tooth, teeth, or gums Broken/chipped tooth Other: _____

EMERGENCY CONTACT INFORMATION:

Name: _____ Who is your medical doctor? _____
Relation: _____
Home Phone: _____ Medical Doctor's Phone: _____
Cell Phone: _____
Work Phone: _____

MEDICAL HISTORY

Please check the box if you currently **have** or **have had** any of the following:

- | | | |
|--|---|--|
| <input type="checkbox"/> Heart attack/stroke | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Cancer/tumors |
| <input type="checkbox"/> Heart surgery/pacemaker | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Liver problems | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Respiratory problems | <input type="checkbox"/> HIV+/ AIDS/ ARC |
| <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Arthritis/rheumatism |
| <input type="checkbox"/> Artificial valves | <input type="checkbox"/> Chest pains | <input type="checkbox"/> Artificial bones/joints |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Psychiatric problems | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Congenital heart defect | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Fainting/seizures/epilepsy |
| <input type="checkbox"/> Stomach problems/ulcers | <input type="checkbox"/> Alcohol/drug abuse | <input type="checkbox"/> Severe/frequent headaches |
| <input type="checkbox"/> Jaw problems TMJ/TMD | <input type="checkbox"/> Tuberculosis/TB | <input type="checkbox"/> Frequent neck pain |
| <input type="checkbox"/> Cosmetic surgery | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Back problems |
| <input type="checkbox"/> X-ray/cobalt treatment | <input type="checkbox"/> Anemia | <input type="checkbox"/> Asthma/difficulty breathing |
| <input type="checkbox"/> Diabetes/hypoglycemia | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> High/low blood pressure | <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Others conditions or surgeries: _____ | | |

- What medications are you taking? Nerve pills Pain killers (including aspirin)
 Tranquilizers Blood thinners Stimulants Muscle relaxers
 Insulin Medications for osteoporosis (in the last 7 years)

Please list any medications you are taking: _____

Do you require antibiotic pre-medication? Yes No

Are you allergic to any of the following? Latex Tetracycline

Dental anesthetics Foods Penicillin Aspirin

Others: _____

Do you use tobacco? Yes No

If so, how used? _____ How much? _____ How long? _____

Do you wear contact lenses? Yes No

For women: Are you taking birth control pills? Yes No

Are you pregnant? Yes No If so, how far along? _____

Are you nursing? Yes No

We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for all services rendered at the time of the visit, unless other arrangements have been made with the office manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges, and any other expenses incurred in collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims or to refer for specialty treatment. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____ **Date:** _____

- Patient Parent or Guardian Spouse