WOMMACK DENTISTRY

PATIENT INFORMATION

Date_____

First Name_____ Middle Initial_____ Last Name_____

I prefer to be called (nickname, etc.)_____ ❑ Male ❑ Female

Address_____

City/State/Zip _____

Date of Birth_____ Social Security No._____

Home Phone_____ Cell Phone_____ Work Phone_____

Email_____ Preferred Method of Confirmation ❑ Text ❑ Email

Employer_____ Occupation_____

❑ Single ❑ Married ❑ Divorced ❑ Widowed Spouse's Name_____ Employer_____

Whom may we thank for referring you?_____

If the patient is a child, what is the name of the ❑ Parent ❑ Guardian _____

Name of Insurance Company _____ Member ID _____

Group No. _____ Contact # _____

Reason for Today's Visit_____ Date of last dental care _____

Former/Current Dentist_____Date of last dental x-rays_____

How often do you floss?_____How often do you brush?_____

Do you require antibiotics before treatment?	❑ Yes	❑ No	Have you ever had:		
Do your gums ever bleed?	❑ Yes	❑ No	Periodontal disease/gum treatment	❑ Yes	❑ No
Have you noticed any mouth odors or bad tastes?	❑ Yes	❑ No	Orthodontics treatment	❑ Yes	❑ No
Do you bite your lips or cheeks frequently?	❑ Yes	❑ No	Oral surgery	❑ Yes	❑ No
Do you have frequent headaches?	❑ Yes	❑ No	An occlusal splint or mouth guard	❑ Yes	❑ No
Do you clench or grind your teeth?	❑ Yes	❑ No	Discomfort in your jaw joint (TMJ/TMD)	❑ Yes	❑ No
Are your teeth sensitive to heat/cold?	❑ Yes	❑ No	Your bite adjusted	❑ Yes	❑ No
Do you still have your wisdom teeth?	❑ Yes	❑ No	Serious injury to the mouth or head	❑ Yes	❑ No

If you answered yes to any of the above, please describe:_____

_____

Is there anything else about your past dental treatment(s) that you would like us to know?_____

_____

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Have you been hospitalized or under the care of a medical doctor during the past two years? ❑ Yes ❑ No

Primary Care Physician_____ City_____ State_____

Have you taken any medications or drugs in the past two years? ❑ Yes ❑ No

Are you currently taking any medications or drugs? (including regular doses of aspirin or over-the-counter medicines) ❑ Yes ❑ No

If yes, please explain_____

Have you ever taken blood thinners or medications or do you have artificial joints? ❑ Yes ❑ No If yes, for how long? _____

Have you visited a doctor because of any heart problems?_____❑ Yes ❑ No

If yes, what was/is the problem? _____

Do you use tobacco? ❑ Yes ❑ No Do you use any other controlled substance? ❑ Yes ❑ No

Women only: Are you pregnant or think you may become pregnant? ❑ Yes ❑ No Are you nursing? ❑ Yes ❑ No
Are you taking birth control pills? ❑ Yes ❑ No

Indicate which of the following you have had or have at present:

ADHD	❑ Yes ❑ No	Cortisone Medicine	❑ Yes ❑ No	Kidney Trouble	❑ Yes ❑ No
AIDS/HIV	❑ Yes ❑ No	Covid	❑ Yes ❑ No	Liver Disease	❑ Yes ❑ No
Alcohol/Drug Abuse	❑ Yes ❑ No	Diabetes	❑ Yes ❑ No	Nervousness/Anxiety	❑ Yes ❑ No
Allergies or Hives	❑ Yes ❑ No	Diet (Special/Restricted)	❑ Yes ❑ No	Neurological Disorders	❑ Yes ❑ No
Anemia	❑ Yes ❑ No	Difficulty Breathing	❑ Yes ❑ No	Psychiatric/Psychological Care	❑ Yes ❑ No
Arthritis/Rheumatism	❑ Yes ❑ No	Emphysema	❑ Yes ❑ No	Radiation Therapy	❑ Yes ❑ No
Artificial Heart Valve	❑ Yes ❑ No	Epilepsy or Seizures	❑ Yes ❑ No	Shingles/Chicken Pox	❑ Yes ❑ No
Artificial Bones/Joints	❑ Yes ❑ No	Fainting or Dizzy Spells	❑ Yes ❑ No	Sickle Cell Disease/Traits	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Frequent Headaches	❑ Yes ❑ No	Sinus Trouble	❑ Yes ❑ No
Autoimmune Disorder	❑ Yes ❑ No	Hay Fever	❑ Yes ❑ No	Snoring/Sleep Apnea	❑ Yes ❑ No
Blood Disease	❑ Yes ❑ No	Heart (Surgery, Disease, Attack)	❑ Yes ❑ No	Stomach Problems/Ulcers	❑ Yes ❑ No
Blood Transfusion	❑ Yes ❑ No	Heart Pacemaker	❑ Yes ❑ No	Stroke	❑ Yes ❑ No
Bruise Easily	❑ Yes ❑ No	Hemophilia/Abnormal Bleeding	❑ Yes ❑ No	Thyroid Problems	❑ Yes ❑ No
Cancer/Chemotherapy	❑ Yes ❑ No	Hepatitis A B C (Circle one)	❑ Yes ❑ No	Tuberculosis (TB)	❑ Yes ❑ No
Cold Sores/Herpes	❑ Yes ❑ No	High/Low Blood Pressure	❑ Yes ❑ No	Tumors	❑ Yes ❑ No
Colitis	❑ Yes ❑ No	HPV	❑ Yes ❑ No		

Please list any serious medical condition(s) that you have ever had not listed above:_____

_____

Are you aware of having an allergic or adverse reactions to any of the following:

NSAIDs	❑ Yes ❑ No	Other Antibiotics	❑ Yes ❑ No	Sedatives	❑ Yes ❑ No
Codeine	❑ Yes ❑ No	Iodine	❑ Yes ❑ No	Sulfa Drugs	❑ Yes ❑ No
Anesthetics (i.e. Novocaine)	❑ Yes ❑ No	Jewelry/Metals	❑ Yes ❑ No		
Penicillin	❑ Yes ❑ No	Latex	❑ Yes ❑ No	Other_____	

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have permission to ask the respective healthcare provider or agency that may release such information to you. I will notify the dentist of any changes in my health or medication.

Patient Signature_____ Date_____

Doctor Signature_____ Date_____