WELCOME to Walls Family Dentistry

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us- we will be happy to help.

PATIENT INFORMATION (CONFIDENTIAL)

Name_____Date_____
Soc. Sec. #_____ Birthday_____ Home Phone_____
Mobile Phone _____ Email Address _____
Address_____ City_____ State_____ Zip_____
Check all that apply: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated Sex ❑ M ❑ F
If Student, Name of School/College_____ City_____ State____ ❑ FT ❑ PT
Patient's or Parent's Employer_____ Work Phone_____
Business Address_____ City_____ State___ Zip_____
Spouse or Parent's Name_____ Employer_____ Work Phone_____
How did you find out about us? _____
Person to contact in case of emergency_____ Phone_____

RESPONSIBLE PARTY

Name of Person Responsible for this Account_____ Relationship to Patient_____
Address_____Home Phone_____
Drivers License #_____ Birth date_____ Financial Institution_____
Employer_____ Work Phone_____ Soc. Sec. #_____
If other than self, is this Person Currently a Patient in our office? ❑ Yes ❑ No
Do you have dental insurance? ❑ Yes ❑ No

PATIENT MEDICAL HISTORY

Physician_____ Office Phone_____ Date of Last Exam_____

	Yes	No
1. Are you under medical treatment now?….....	❑	❑
2. Have you ever been hospitalized for any surgical operation or serious illness?.....	❑	❑
3. Are you taking any medication{s} including non-prescription medicine?.....	❑	❑
If yes, what medication{s} are you taking _____		
4. Do you use tobacco?.....	❑	❑
5. Do you use controlled substances?.....	❑	❑
6. Do you wear contact lenses?.....	❑	❑
7. Have you ever taken prescription diet pills?.....	❑	❑

8. Are you allergic to or have you had any reactions to the following?	Yes	No
Local Anesthetics{eg. Novocaine}.....	❑	❑
Penicillin or any other Antibiotics.....	❑	❑
Sulfa Drugs.....	❑	❑
Barbiturates/ Sedatives/ Sleeping pills.....	❑	❑
Codeine or other narcotics.....	❑	❑
Iodine.....	❑	❑
Asprin.....	❑	❑
Any Metals{eg. nickel, mercury, etc.}.....	❑	❑
Latex Rubber.....	❑	❑
Other {Please list}_____		

9. Women only:
a)Are you pregnant or think you may be? Yes ❑ No ❑ b)Are you taking oral contraceptives? Yes ❑ No ❑ c)Are you nursing? Yes ❑No ❑

10. Do you have any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	❑	❑	Heart Disease	❑	❑	Chest Pains	❑	❑
Abnormal Bleeding	❑	❑	Blood Transfusion	❑	❑	Immune System Problems	❑	❑
Neurologic Disease	❑	❑	Mental health problems	❑	❑	Blood Disorder/Anemia	❑	❑
Heart Attack	❑	❑	Cardiac Pacemaker	❑	❑	Easily Winded	❑	❑
Rheumatic Fever	❑	❑	Heart Murmur	❑	❑	Stroke	❑	❑
Swollen Ankles	❑	❑	Angina	❑	❑	Hayfever/Allergies	❑	❑
Fainting/Seizures	❑	❑	Frequently Tired	❑	❑	Tuberculosis	❑	❑
Asthma	❑	❑	Hearing Loss	❑	❑	Radiation Therapy	❑	❑
Low Blood Pressure	❑	❑	Emphysema	❑	❑	Glaucoma	❑	❑
Epilepsy/Convulsions	❑	❑	Cancer	❑	❑	Recent Weight Loss	❑	❑
Leukemia	❑	❑	Arthritis/Painful Swollen Joints	❑	❑	Liver Disease	❑	❑
Diabetes	❑	❑	Joint Replacement or Implant	❑	❑	Heart Trouble	❑	❑
Kidney Diseases	❑	❑	Hepatitis/Jaundice	❑	❑	Respiratory Problems	❑	❑
Aids or HIV Infection	❑	❑	Sexually Transmitted Disease	❑	❑	Heart Surgery	❑	❑
Mitral Valve Prolapse	❑	❑	Thyroid Problem	❑	❑	Stomach Troubles/Ulcers	❑	❑
			Alcoholism/Drug Abuse	❑	❑	Other	❑	❑

Patient Dental History

Name of Previous Dentist and Location_____ Date of Last Exam/Cleaning_____

	Yes	No		Yes	No
1. Do your gums bleed while brushing or flossing?	❑	❑	9. Do you clench or grind your teeth?	❑	❑
2. Are your teeth sensitive to hot or cold liquids/foods?	❑	❑	10. Do you bite your lips or cheeks frequently?	❑	❑
3. Are your teeth sensitive to sweet or sour liquids/foods?	❑	❑	11. Have you ever had any difficult extractions?	❑	❑
4. Do you feel pain in any of your teeth?	❑	❑	12. Have you had prolonged bleeding after extractions?	❑	❑
5. Do you have any sores or lumps in or near your mouth?	❑	❑	13. Have you had any orthodontic treatment?	❑	❑
6. Have you had any head, neck or jaw injuries?	❑	❑	14. Do you wear dentures or partials?	❑	❑
7. Have you ever experienced any of the following jaw problems?			If yes, date of placement_____		
Clicking? Yes ❑ No ❑ Pain (joint, ear, side of face) Yes ❑ No ❑			15. Have you ever received oral hygiene instructions		
Difficulty opening or closing? Yes ❑ No ❑			regarding the care of your teeth and gums?	❑	❑
Difficulty Chewing? Yes ❑ No ❑			16. Do you like your smile?	❑	❑
8. Do you have frequent headaches?	❑	❑	17. Do you have an ongoing problem with bad breath?	❑	❑

Authorization and Release

I certify that I have read and understand the above information. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I consent to treatment as necessary or desirable to the care of the patient named above, for the diagnosis of dental disease, deformity, or treatment of dental emergencies. These procedures may include radiographs, models, and intraoral examinations. In case of dental emergency, I consent to treatment as deemed necessary by the doctor, understanding that the procedures will be explained in advance, except in those instances when the procedures change during the course of treatment. I understand that, while quite rare, local anesthesia can cause unintended temporary or permanent loss of feeling to the lips, cheeks, tongue, teeth, etc. I give my consent to the use of local anesthetic and medication for completing the necessary dental treatment. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient or parent if a minor _____ Date_____

Signature of Doctor/Hygenist_____ Date _____