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, and we will be happy to help.

PATIENT INFORMATION (CONFIDENTIAL)

Name_____Date_____

Soc. Sec. #_____ Birth date_____ Home Phone_____

Address_____ City_____ State_____ Zip_____

Cell Phone _____ Email Address _____

Check all that apply: □ Minor □ Single □ Married □ 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. #_____

Cell Phone _____ Email Address _____

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 or medical marijuana?…. 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. Do you have a medical marijuana card? …….....	□	□

8. Are you allergic to or have you had any reactions to the following?	YES	NO
Local Anesthetics {e.g. Novocain}…….....	□	□
Penicillin or any other Antibiotics...……..……	□	□
Sulfa Drugs……..	□	□
Barbiturates/ Sedatives/ Sleeping pills……...	□	□
Codeine or other narcotics…..…….....	□	□
Iodine……...	□	□
Aspirin…….....	□	□
Any Metals {egg. nickel, mercury, etc.}……...…….	□	□
Latex Rubber……...	□	□
Other {Please list}…….……...	□	□
9. Women only		
a) Are you pregnant or think you may be? ……..…	□	□
b) Are you taking oral contraceptives? ……..….	□	□
c) Are you nursing? ……..…..	□	□

10. Do you have any of the following?

	YES	NO
Premed for Dental Work……	☐	☐
Abnormal Bleeding……	☐	☐
Allergies/Hay fever……	☐	☐
Alzheimer's/Dementia……	☐	☐
Anemia……	☐	☐
Angina……	☐	☐
Arthritis/Painful Swollen Joints.	☐	☐
Artificial Joints……	☐	☐
Asthma……	☐	☐
Blood Diseases……	☐	☐
Blood Pressure-High……	☐	☐
Blood Pressure-Low……	☐	☐
Blood Thinner……	☐	☐
Blood Transfusion……	☐	☐
Cancer……	☐	☐
Chest Pains……	☐	☐
Depression……	☐	☐
Diabetes……	☐	☐
Dizziness/Fainting……	☐	☐
Emphysema……	☐	☐

	YES	NO
Epilepsy/Seizures……	☐	☐
Frequently Tired……	☐	☐
Glaucoma……	☐	☐
Growths/Tumors……	☐	☐
Head/Neck Injury ……	☐	☐
Hearing Difficulties……	☐	☐
Heart Attack……	☐	☐
Heart Disease……	☐	☐
Heart Murmur……	☐	☐
Heart Surgery……	☐	☐
Hepatitis/Jaundice……	☐	☐
HIV/AIDS……	☐	☐
Immune System Problems……	☐	☐
Joint Replacement……	☐	☐
Kidney Diseases……	☐	☐
Leukemia……	☐	☐
Liver Disease……	☐	☐
Mental health problems……	☐	☐
Migraines/Frequent Headaches..	☐	☐
Mitral Valve Prolapse……	☐	☐

	YES	NO
Nervous Disorders…….	☐	☐
Neurologic Diseases…..	☐	☐
Pacemaker……..	☐	☐
Parkinson's Disease…...	☐	☐
Radiation Treatment…..	☐	☐
Respiratory Problems…	☐	☐
Rheumatic Fever……...	☐	☐
Sinus Problems……..	☐	☐
Sleep Apnea……...	☐	☐
Snoring……...	☐	☐
STD/HPV……...	☐	☐
Stomach Troubles……...	☐	☐
Stroke……..	☐	☐
Substance Abuse……..	☐	☐
Thyroid Disorder……	☐	☐
Tuberculosis……...	☐	☐
Ulcers……..	☐	☐
Other……	☐	☐

Patient Dental History

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

	YES	NO
1. Do your gums bleed while brushing or flossing? ……	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods? …	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain in any of your teeth? ……..	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you ever experienced any of the following jaw problems?		
Clicking…….	☐	☐
Pain (joint, ear, side of face)…….	☐	☐
Difficulty in opening or closing……	☐	☐
Difficulty in chewing……	☐	☐
9. Do you clench or grind your teeth?.....	☐	☐

	YES	NO
10. Do you bite your lips or cheeks frequently?.....	☐	☐
11. Have you ever had any difficult extractions?.....	☐	☐
12. Have you ever had any prolonged bleeding following extractions? ……	☐	☐
13. Have you had any orthodontic treatment? ……..	☐	☐
14. Do you wear dentures or partials?.....	☐	☐
If yes, date of placement_____		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?……..…	☐	☐
16. Do you like your smile? ……..……..	☐	☐
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 _____