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 school do they attend?__________________________________ Grade________

Reason for Today's Visit______________________________ Date of last dental care______________________________

Former Dentist______________________________ Date of last dental x-rays______________________________

Address____

How often do you floss?______________________________ How often do you brush?______________________________

Do you require antibiotics before treatment?	❑ Yes	❑ No
Do your gums ever bleed?	❑ Yes	❑ No
Have you noticed any mouth odors or bad tastes?	❑ Yes	❑ No
Do you bite your lips or cheeks frequently?	❑ Yes	❑ No
Do you have frequent headaches?	❑ Yes	❑ No
Do you clench or grind your teeth?	❑ Yes	❑ No
Are your teeth sensitive to heat/cold?	❑ Yes	❑ No
Do you still have your wisdom teeth?	❑ Yes	❑ No

Have you ever had:

Periodontal disease/gum treatment	❑ Yes	❑ No
Orthodontics treatment	❑ Yes	❑ No
Oral surgery	❑ Yes	❑ No
An occlusal splint or mouth guard	❑ Yes	❑ No
Discomfort in your jaw joint (TMJ/TMD)	❑ Yes	❑ No
Your bite adjusted	❑ 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?______________________

____

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 Fen-Phen? ❑ Yes ❑ No If yes, for how long?________________________________

Have you ever taken Bisphosphonates or other Osteoporosis medications? ❑ 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 alcohol or 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:

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

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

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

Aspirin	❑ Yes ❑ No	Iodine	❑ Yes ❑ No	Sedatives	❑ Yes ❑ No
Codeine	❑ Yes ❑ No	Jewelry/Metals	❑ Yes ❑ No	Sulfa Drugs	❑ Yes ❑ No
Anesthetics (i.e. Novocaine)	❑ Yes ❑ No	Latex	❑ Yes ❑ No	Tetracycline	❑ Yes ❑ No
Erythromycin	❑ Yes ❑ No	Penicillin/Other Antibiotics	❑ 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__________________