Walnut Hill
DENTAL ASSOCIATES

PATIENT INFORMATION:

First Name: ________________________ MI: _________ Last Name:______________________________ Sex: ☐ Male ☐ Female

Preferred Name: _________ Birthdate: ______/______/______ SS#:_______________ E-Mail Address: ________________________

Mailing Address: ____ City: ________________ State: _______ Zip:_________________

Home Phone: ________________________ Cell Phone: _______________________ Work Phone: ___________________________

Occupation: __________________________ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

How did you hear about our office? ____

OPTIONAL: Preferred pronouns: ____

RESPONSIBLE PARTY (If different from above):

Name: ____________________________________ Relation: ______________________ Phone Number: _____________________

Billing Address: ____ City: ________________ State: _____ Zip: ___________

INSURANCE INFORMATION:

Primary Dental Insurance Company: ____ Phone Number: ________________

Address: ____ City: _____________ State: ____________ Zip:__________

ID Number: ______________________ Group Number: _________________ Employer: _________________________________

Insured's Name: _________________________________ Relation: __________________________ DOB: ______/______/______

Secondary Dental Insurance Company: ____ Phone Number: ______________

Address: ____ City: _____________ State: ____________ Zip:__________

ID Number: ______________________ Group Number: _________________ Employer: _________________________________

Insured's Name: _________________________________ Relation: __________________________ DOB: ______/______/______

EMERGENCY CONTACT INFORMATION:

Name: ____ Phone Number: ___________________ Relationship: ______________

Medical Doctor Name: ____ Phone Number: _______________________________

DENTAL INFORMATION:

What is the reason for your visit today? ____

Are you experiencing any dental pain? □ Yes □ No When did it start? ______________________________

Previous Dentist: ________________________________ Date of last dental exam: ____________________

Please indicate if you are experiencing any of the following:

☐ Discomfort, clicking or popping in jaw ☐ Lost/broken filling(s) ☐ Stained teeth ☐Dry mouth

☐ Red, swollen, sensitive or bleeding gums ☐ Grinding of teeth ☐ Sensitive teeth ☐ Bad breath

☐ Blisters/sores in or around the mouth ☐ Broken/chipped teeth ☐ History of trauma to the mouth/teeth

How often do you brush? ____________________ How often do you floss? ____________________________

What type of toothbrush do you use? □ Manual □ Electric Bristle type? □ Soft □ Medium □ Hard

Do you have a history of periodontal treatment/"deep cleaning"/gum surgery? ________________ Date: ____________

Do you require pre-medication? □ Yes □ No For what condition? ______________________________________

Are you satisfied with your smile? □ Yes □ No

What would you change about it, if possible? ____

MEDICAL HISTORY:

Do you have or have you previously had any of the following medical conditions?

Y N Heart attack/stroke	**Y N** Heart surgery/pacemaker	**Y N** Heart murmur	**Y N** Rheumatic fever
Y N Artificial valves	**Y N** Thyroid problems	**Y N** Kidney problems	**Y N** Liver problems
Y N Respiratory problems	**Y N** Stomach problems/ulcers	**Y N** Sinus problems	**Y N** Psychiatric problems
Y N Depression or anxiety	**Y N** Venereal disease	**Y N** Tuberculosis (TB)	**Y N** Cancer/tumors
Y N Chemotherapy	**Y N** Shingles	**Y N** Hepatitis	**Y N** HIV+/AIDS
Y N Arthritis	**Y N** Emphysema	**Y N** Seizures/epilepsy	**Y N** Frequent neck pain
Y N Frequent headaches	**Y N** Back problems	**Y N** Asthma	**Y N** Difficulty breathing
Y N Diabetes/hypoglycemia	**Y N** Leukemia	**Y N** Anemia	**Y N** High blood pressure
Y N Low blood pressure	**Y N** Bleeding problems	**Y N** Glaucoma	**Y N** Herpes/cold sores

Please list any other medical conditions not covered:

____

____

Please list all medications you are currently taking, including vitamins, supplements, and over-the-counter medications:

____

____

Have you ever taken bisphosphonates such as Boniva/Fosamax? □ Yes □ No

Date you began this medication: ____________________________

Have you received the HPV (human papilloma virus) vaccine? □ Yes □ No

Have you ever had a total joint replacement? □ Yes □ No

Joint(s) replaced: ____Date of surgery: _______________________________________

Please list any other hospitalizations or surgeries with dates:

____

____

ALLERGIES:

Are you allergic to any of the following? ☐ Latex ☐ Penicillin ☐ Sulfa drugs ☐ Aspirin

☐ Dental Anesthetics ☐ Foods: __________________________________ ☐ Other: ________________________________

SOCIAL HISTORY:

Do you use/have you previously used any of the following:

Cigarettes: ☐ Yes ☐ No

Chewing tobacco: ☐ Yes ☐ No

Vape pen/e-cigarette: ☐ Yes ☐ No

Recreational drugs (not including marijuana): ☐ Yes ☐ No

Alcoholic beverages: ☐ Yes ☐ No

Number per week: _________________________

Are you pregnant? ☐ Yes ☐ No ☐ Not Applicable

If yes, when is your due date? ______________________

Are you nursing? ☐ Yes ☐ No ☐ Not Applicable

Are you taking birth control pills? ☐ Yes ☐ No ☐ Not Applicable

To the best of my knowledge, the questions above have been accurately answered and the information provided is factual. I understand that I am responsible for updating the office of any changes to this information at future visits. I understand that providing inaccurate information can be harmful to my oral and/or overall health.

____ _________________________________

Signature of Patient, Parent, or Guardian

Date