180 Commerce Park Drive, Suite B
Westerville, OH 43082
info@westervilledentalhealth.com
(614) 882-6741

Patient Information

First Name: _____ Last Name: _____

Preferred Name/Nickname: _____ SS #: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

How long at this address?: _____ Birthdate: _____

Marital Status: ___ Single ___ Married ___ Widowed ___ Separated ___ Divorced

Email Address: _____

Sex ___ M ___ F Home Phone: _____

Work Phone: _____ Cell Phone: _____

Patient Employed by: _____ Occupation: _____

Whom may we thank for referring you?: _____

In case of emergency, who should be notified? (Someone not living in your household):

_____

Emergency Relation: _____ Emergency Phone: _____

Dental History

Reason for today's visit: _____

Any other dental questions or concerns: _____

Date of last dental visit: _____ Date of last dental x-rays: _____

Would you like whiter teeth?: ___ Yes ___ No

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Medications

List medications you are currently taking:

FOSAMAX (Bisphosphonate) ___ Yes ___ No

ACTONEL ___ Yes ___ No

BONIVA ___ Yes ___ No

Other _____

_____

Allergies

___ Aspirin

___ Barbiturates (sleeping pills)

___ Codeine

___ Local Anesthetic

___ Penicillin

___ Sulfa

___ Latex

Other _____

Health History

Physician's Name: _____ Date of last visit: _____

(Women)	Are you pregnant?	___ Yes ___ No
	Nursing?	___ Yes ___ No
	Taking oral contraceptives?	___ Yes ___ No
	Have you had surgery in the last 6 months?	___ Yes ___ No
	Do you need to be premedicated for dental work?	___ Yes ___ No

Check if you have had any of the following:

___ Stroke	___ Sinus Trouble	___ HIV
___ Heart Disease/Surgery	___ Asthma	___ Hives or Rash
___ Heart Murmur	___ Bloody Sputum	___ Drug Addiction/
___ Irregular Heart Beat	___ Emphysema	Alcoholism
___ Angina/Chest Pain	___ Tuberculosis (TB)	___ Cold Sores

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___ Heart Attack/Failure
___ Congenital Heart Disorder
___ Mitral Valve Prolapse
___ Scarlet Fever
___ Rheumatic Fever
___ Artificial Heart Valve
___ Heart Pacemaker
___ Pulmonary Shunt
___ High Blood Pressure
___ Low Blood Pressure
___ Bacterial Endocarditis
___ Leukemia
___ Other Blood Disorders
___ Lung Disease
___ Frequent Cough

___ Cancer
___ Radiation
___ Chemotherapy
___ Ulcers
___ Recent Weight Loss
___ Diabetes
___ Liver Disease
___ Hepatitis
___ Kidney Problems
___ Renal Dialysis
___ Thyroid Disease
___ Arthritis/Gout
___ Rheumatism
___ Cortizone Medicine
___ Artificial Joint

___ Fever Blisters
___ Herpes
___ Convulsions
___ Epilepsy or Seizure
___ Fainting or Dizziness
___ Glaucoma
___ Tumors or Growths
___ Nervousness
___ Psychiatric Care
___ Ever taken fen-phen?

Other: _____
_____
_____
_____

Authorization and Release

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

Patient Signature (or parent if minor): _____