Patient **Confidential**

☐ Mr ☐ Ms ☐ Mrs ☐ Miss	Name of Patient			Date of Birth			Age
	Last	First	Middle	Month	Day	Year	
Home Address		City	Zip	Telephone			
Patient's Social Security No.		Drivers License No.		Cell			
Occupation	Employer (Name and Address) or School			Telephone			

Responsible Party

Relationship	Name	Address, If Different	Telephone

Dental Plan

Insurance Co. Name		Telephone			
Primary Member Name	Social Security No.	Date of Birth			Age
		Month	Day	Year	
Group No.	Plan No.				
Second Insurance					

Dental History

Why are you here today? ☐ Estimate ☐ Check-up ☐ Toothache ☐ Other

How long since your last dental visit? __________

How did you hear about this office?

☐ Radio ☐ Phone Book ☐ Friend (Patient) Name ____________________________

☐ Newspaper ☐ TV ☐ Saw the Building ☐ Other

Medical History

Are you in good health? ☐ Yes ☐ No

Physician's Name	Telephone	Date of Last Visit

Have you had any serious Illness or operation? ☐ Yes ☐ No

Have you had a blood transfusion? ☐ Yes ☐ No

Have you had problems with prior dental treatment? ☐ Yes ☐ No

Has your health changed within the last year? ☐ Yes ☐ No

Women Only:

Are you pregnant or could you be? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

Are you taking birth control pills? ☐ Yes ☐ No

Check yes or no if you have or had any of the following:

High Blood Pressure	☐ Yes ☐ No	Cardiac Pacemaker	☐ Yes ☐ No	Hay Fever/Allergies	☐ Yes ☐ No
Heart Attack	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Rheumatic Fever	☐ Yes ☐ No	Angina	☐ Yes ☐ No	Radiation Therapy	☐ Yes ☐ No
Swollen Ankles	☐ Yes ☐ No	Frequently Tired	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No
Fainting/Seizures	☐ Yes ☐ No	Anemia	☐ Yes ☐ No	Recent Weight Loss	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
Low Blood Pressure	☐ Yes ☐ No	Cancer	☐ Yes ☐ No	Heart Trouble	☐ Yes ☐ No
Epilepsy/Convulsions	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No	Respiratory Problems	☐ Yes ☐ No
Leukemia	☐ Yes ☐ No	Joint Replacement/Implant	☐ Yes ☐ No	Have you ever had any prolonged bleeding?	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Hepatitis/Jaundice	☐ Yes ☐ No		
Kidney Diseases	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No		
AIDS or HIV Infection	☐ Yes ☐ No	Stomach Problems/Ulcers	☐ Yes ☐ No	Have you ever taken Phen fen?	☐ Yes ☐ No
Thyroid Problem	☐ Yes ☐ No	Chest Pains	☐ Yes ☐ No		
Heart Disease	☐ Yes ☐ No	Easily Winded	☐ Yes ☐ No	Fosamax	☐ Yes ☐ No
Tonsilitis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No	Other	☐ Yes ☐ No

Do you or have you had any other diseases or medical problems NOT listed on this form? ☐ Yes ☐ No

If yes, please explain: ____

Allergies

Penicillin	☐ Yes ☐ No	Aspirin	☐ Yes ☐ No
Sulfa	☐ Yes ☐ No	Barbiturate	☐ Yes ☐ No
Codeine	☐ Yes ☐ No	Local Anethetic	☐ Yes ☐ No
Latex	☐ Yes ☐ No	Other	☐ Yes ☐ No

Medications

List any medications you are currently taking	
Pharmacy name and phone	

Authorization and Release

This is my consent to the examination and dental performed at this office. Wow Dental agrees to provide their professional services by their doctor and employees to their patients. I certify that I have read and understand the above information to the best of my knowledge and that the above questions have been accurately answered. I understand that provided incorrect information can be dangerous to my health. I authorize the dentist to release any information, including diagnosis and the records of any treatment or examination rendered to me or my child, to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group. 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.

X________________________________ Date______________

Signature of Patient or Parent (if Minor)

X________________________________ Date ___________

Signature of Reviewing Dentist