HEALING
Wings Dental

PATIENT INFORMATION

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PATIENT OR PARENT'S EMPLOYER _____

BUSINESS ADDRESS _____

CITY _____ STATE _____ ZIP _____

IF PT IS A STUDENT, NAME OF SCHOOL _____

CITY _____ STATE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

_____

CONFIDENTIAL

BIRTHDATE _____

HOME PHONE _____

CIRCLE APPROPRIATE SELECTION:

MINOR ◯ SINGLE ◯ MARRIED ◯

DIVORCED ◯ WIDOWED ◯ SEPERATED ◯

WORK PHONE _____

CELL PHONE _____

OTHER _____

EMAIL _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____

_____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMPLOYER _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

RELATIONSHIP TO PATIENT _____

HOME PHONE _____

WORK PHONE _____

CELL PHONE _____

BIRTHDATE _____

SS NUMBER _____

INSURANCE INFORMATION

NAME OF INSURED _____

INSURANCE COMPANY _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

RELATIONSHIP TO PATIENT _____

BIRTHDATE _____

SS NUMBER _____

GROUP NUMBER _____

PATIENT NAME _____

INSURANCE PHONE _____

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ADDITIONAL INSURANCE

NAME OF INSURED _____

RELATIONSHIP TO PATIENT _____

INSURANCE COMPANY _____

BIRTHDATE _____

ADDRESS _____

SS NUMBER _____

CITY _____ STATE _____ ZIP _____

GROUP NUMBER _____

INSURANCE PHONE _____

PATIENT MEDICAL HISTORY

PHYSICIAN NAME _____

PHYSICIAN PHONE _____

	YES	NO
• ARE YOU UNDER THE CARE OF A PHYSICIAN	○	○
• HAVE YOU BEEN HOSPITALIZED IN THE LAST FIVE YEARS	○	○
• ARE YOU TAKING MEDICATIONS? INCLUDING OVER THE COUNTER AND PRESCRIPTION.	○	○
• DO YOU USE TOBACCO?	○	○
• DO YOU USE ALCOHOL?	○	○
• DO YOU USE COCAINE OR OTHER DRUGS?	○	○
• DO YOU WEAR CONTACTS?	○	○
• DO YOU HAVE ANY ALLERGIES?	○	○

_____

_____

- HAVE YOU EVER HAD A REACTION TO ANESTHETIC? YES ○ NO ○

EXPLAIN ABOVE: _____

_____

_____

DATE OF LAST EXAM _____

WOMEN ONLY:

- ARE YOU PREGNANT _____
- ARE YOU NURSING _____
- ARE YOU TAING BIRTH CONTROL PILLS _____

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS ABOUT YOURSELF: (*MARK ALL ANSWERS WITH A YES OR NO)*

	YES	NO		YES	NO		YES	NO
HIGH BLOOD PRESSURE	○	○	FREQUENTLY TIRED	○	○	KIDNEY DISEASE	○	○
HEART ATTACK	○	○	ANEMIA	○	○	AIDS/HIV INFECTION	○	○
RHEUMATIC FEVER	○	○	EMPHYSEMA	○	○	STD'S	○	○
SWOLLEN ANKLES	○	○	CANCER	○	○	THYROID PROBLEMS	○	○
FAINING/SEIZURES	○	○	ARTHRITIS	○	○	HEPATITIS A, B OR C	○	○
ASTHMA	○	○	JOINT REPLACEMENT	○	○	ULCERS	○	○
LOW BLOOD PRESSURE	○	○	CHEST PAINS	○	○	RESPIRATORY PROBLEMS	○	○
EPILEPSY/CONVULSIONS	○	○	SHORT OF BREATH	○	○	OTHER _____		
LEUKEMIA	○	○	STROKE	○	○	_____		
DIABETES	○	○	HAY FEVER/ALLERGIES	○	○	_____		
HEART DISEASE	○	○	TUBERCULOSIS	○	○	_____		
CARDIAC PACE MAKER	○	○	RADIATION THERAPY	○	○	_____		
HEART MURMER	○	○	GLAUCOMA	○	○	_____		

ANGINA ◯ ◯ **LIVER DISEASE** ◯ ◯

PATIENT NAME _____ **PAGE 3**

PATIENT DENTAL HISTORY

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 YOUR MOUTH?** _____
6. **HAVE YOU EVER SUFFERED TRAUMA TO YOUR FACE MOUTH OR JAW?** _____
7. **DOES YOUR JAW EVER CLICK, POP, CRACKLE OR ACHE?** _____
8. **DO YOU HAVE PAIN IN YOUR JAW JOINT, EAR OR SIDE OF THE FACE?** _____
9. **DO YOU HAVE DIFFICULTY OPENING OR CLOSING YOUR MOUTH?** _____
10. **DO YOU HAVE DIFFICULTY CHEWING?** _____
11. **DO YOU HAVE FREQUENT HEADACHES?** _____
12. **DO YOU CLENCH OR GRIND YOUR TEETH?** _____
13. **DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?** _____
14. **HAVE YOU HAD PROBLEMS WITH PREVIOUS DENTAL WORK?** _____
15. **HAVE YOU EVER HAD BRACES?** _____
16. **HOW MANY TIMES A DAY DO YOU BRUSH YOUR TEETH?** _____
17. **HOW OFTEN DO YOU FLOSS?** _____
18. **DO YOU USE A MANUAL BRUSH OR ELECTRIC?** _____
19. **DO YOU USE ANY TYPE OF MOUTH RINSE?** _____

GOALS FOR YOUR MOUTH, TEETH AND SMILE: _____

_____

_____

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD THAT BE? _____

_____

_____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been answered accurately. I understand that providing false or incorrect information can be dangerous to my health.

_____ _____
PATIENT SIGNATURE DATE

_____
PRINT NAME

_____
DENTIST SIGNATURE

_____
DATE

_____
WITNESS SIGNATURE

_____
DATE