

ROBERT V. WICK, D.D.S.

Patient's Name \_\_\_\_\_ What do you prefer to be called? \_\_\_\_\_

Sex:  M  F Birthdate \_\_\_\_\_  Single  Married Spouse's Name \_\_\_\_\_

Whom may we thank for referring you to this office? \_\_\_\_\_

If you are a student over age 18, please enter the name of your school \_\_\_\_\_

ACCOUNT INFORMATION

Please provide us with the person who will pay for any care which is not covered by insurance.

Responsible Party \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Telephone \_\_\_\_\_ Work Telephone \_\_\_\_\_ Social Security Number \_\_\_\_\_

Employed by \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Present Position \_\_\_\_\_ How Long? \_\_\_\_\_

Do you have dental insurance?  Yes  No If yes, please complete the following:

If you do not have dental insurance, skip to the next page

MR./HUSBAND/FATHER'S INSURANCE CARRIER

Employee's Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Social Security Number \_\_\_\_\_ Birthdate \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Carrier's Name \_\_\_\_\_ Group # \_\_\_\_\_

Address \_\_\_\_\_ Union or Local # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Patient relationship to the employee.  Self  Spouse  Child  Other

MRS./WIFE/MOTHER'S INSURANCE CARRIER

Employee's Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Social Security Number \_\_\_\_\_ Birthdate \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Carrier's Name \_\_\_\_\_ Group # \_\_\_\_\_

Address \_\_\_\_\_ Union or Local # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Patient relationship to the employee.  Self  Spouse  Child  Other

# Dental History

Reason for seeking care today:  Exam  Cleaning  Specific Problem \_\_\_\_\_  
(Please describe)

How long since you have been to a dentist? \_\_\_\_\_

What was done then? \_\_\_\_\_

Please check all that apply:

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Toothache                    | <input type="checkbox"/> Bite or teeth have shifted           | <input type="checkbox"/> Cracked, chapped lips             | <input type="checkbox"/> Unable to open mouth wide                                |
| <input type="checkbox"/> Broken filling or tooth      | <input type="checkbox"/> Often bite cheeks                    | <input type="checkbox"/> Bad taste in mouth                | <input type="checkbox"/> Jaw gets tired easily                                    |
| Sensitivity to:                                       | <input type="checkbox"/> Frequent dry mouth                   | <input type="checkbox"/> Sinus problems                    | <input type="checkbox"/> Hold things between teeth<br>(Pipe, pencil, nails, pins) |
| <input type="checkbox"/> Cold                         | <input type="checkbox"/> Concerned about breath               | <input type="checkbox"/> Mouth breath - asleep<br>or awake | <input type="checkbox"/> Bite fingernails   |
| <input type="checkbox"/> Hot                          | <input type="checkbox"/> Unhappy with previous<br>dental work | <input type="checkbox"/> Dry or strained eyes              | <input type="checkbox"/> Unusual habits with teeth                                |
| <input type="checkbox"/> Sweets                       | <input type="checkbox"/> Gums bleed                           | <input type="checkbox"/> Shoulder, neck or headaches       | <input type="checkbox"/> Wore braces  |
| <input type="checkbox"/> Chewing                      | <input type="checkbox"/> Gums tender                          | <input type="checkbox"/> Clench or grind teeth             | <input type="checkbox"/> Previous gum treatment                                   |
| <input type="checkbox"/> Food catches                 | <input type="checkbox"/> Growths, sores                       | <input type="checkbox"/> Jaw joint pain                    | <input type="checkbox"/> Previous bite treatment                                  |
| <input type="checkbox"/> Loose teeth                  | <input type="checkbox"/> Cold sores, fever blisters           | <input type="checkbox"/> Clicking or popping of joint      | <input type="checkbox"/> Other  |
| <input type="checkbox"/> Floss breaks easily or hurts |   |  |   |

Would you like whiter teeth?  Yes  No Is there anything that bothers you (even just a little) about the appearance of your teeth or smile? \_\_\_\_\_

Please rate 1 - 10 how anxious you are about dental treatment (1 = totally relaxed) \_\_\_\_\_

Have you ever experienced nitrous oxide analgesia? (gas) \_\_\_\_\_

Have you ever had a bad experience at the dentist? (Treatment? Staff? Billing?) What happened? \_\_\_\_\_

Why did you leave your previous dentist? \_\_\_\_\_

## Medical History

Physician's Name \_\_\_\_\_ City \_\_\_\_\_

Telephone \_\_\_\_\_

Have you been hospitalized for any reason? Please describe:  
\_\_\_\_\_  
\_\_\_\_\_

Are you taking any medications or drugs including nutritional supplements? Please list:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you allergic to penicillin, aspirin, local anesthetics, latex, sulfa, codeine, other?  
\_\_\_\_\_  
\_\_\_\_\_

Do you smoke?  Yes  No How much/day? \_\_\_\_\_

Pregnant?  Yes  No Due date: \_\_\_\_\_

Are you nursing?  Yes  No

Are you seeing a physician now or planning to see one for any reason? Please explain:  
\_\_\_\_\_  
\_\_\_\_\_

Please check all that apply:

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Previous Injury to Head or Neck | <input type="checkbox"/> Family History of Diabetes      | <input type="checkbox"/> Sickle Cell              | <input type="checkbox"/> Shortness of Breath           |
| <input type="checkbox"/> Heart Problem                   | <input type="checkbox"/> Family History of Heart Disease | <input type="checkbox"/> Digestive Problem, Ulcer | <input type="checkbox"/> Snoring, Sleep Apnea          |
| <input type="checkbox"/> Heart Attack                    | <input type="checkbox"/> Other _____                     | <input type="checkbox"/> Thyroid Disease          | <input type="checkbox"/> Easily Winded                 |
| <input type="checkbox"/> Angina Chest Pain               | <input type="checkbox"/> HIV or AIDS                     | <input type="checkbox"/> Glaucoma                 | <input type="checkbox"/> No Energy                     |
| <input type="checkbox"/> Heart Murmur                    | <input type="checkbox"/> Kidney Problem                  | <input type="checkbox"/> Bleed or Bruise easily   | <input type="checkbox"/> Fainting or Dizzy             |
| <input type="checkbox"/> Scarlet, Rheumatic Fever        | <input type="checkbox"/> Liver Problem, Jaundice         | <input type="checkbox"/> Stroke                   | <input type="checkbox"/> Unexplained Weight Loss       |
| <input type="checkbox"/> Mitral Valve Prolapse           | <input type="checkbox"/> Cirrhosis, Hepatitis            | <input type="checkbox"/> Epilepsy or Seizures     | <input type="checkbox"/> Chewing Tobacco               |
| <input type="checkbox"/> Irregular Heartbeat             | <input type="checkbox"/> Cancer                          | <input type="checkbox"/> Parkinson's              | <input type="checkbox"/> Drug or Alcohol Addiction     |
| <input type="checkbox"/> High or Low Blood Pressure      | <input type="checkbox"/> Radiation, Chemo                | <input type="checkbox"/> Alzheimer's              | <input type="checkbox"/> 2 or more Social Drinks/Day   |
| <input type="checkbox"/> Pacemaker                       | <input type="checkbox"/> Respiratory Problem             | <input type="checkbox"/> Back Problem             | <input type="checkbox"/> Anxiety or Nervous Problem    |
| <input type="checkbox"/> Artificial Joint                | <input type="checkbox"/> Bloody, Persistent Cough        | <input type="checkbox"/> Hives, Rash, Herpes      | <input type="checkbox"/> Insomnia, Depression          |
| <input type="checkbox"/> Diabetes                        | <input type="checkbox"/> Asthma, Emphysema               | <input type="checkbox"/> Dry Eyes                 | <input type="checkbox"/> Frustrated, Worried, Too Busy |
|  | <input type="checkbox"/> Anemia                          | <input type="checkbox"/> Contact Lenses           |  |

Any other illnesses not checked above: \_\_\_\_\_

Would you prefer to speak privately with the dentist about a medical issue:  Yes  No

Please rate your daily stress level: 1 - 10 (1 = lowest stress): 1  2  3  4  5  6  7  8  9  10

I certify that the above information is complete and accurate to the best of my knowledge. I will inform this office of any changes in my health status. I understand that dental treatment and local anesthesia entail risks such as bleeding, infection, nerve damage or fracture of teeth or bone.

I CONSENT TO DENTAL TREATMENT AS NECESSARY OR DESIRABLE FOR PATIENT NAMED ABOVE AND ALSO ACKNOWLEDGE FULL RESPONSIBILITY FOR PAYMENT OF SUCH SERVICES.

SIGNED \_\_\_\_\_

PATIENT OR PARENT

DATE