Complete Family Dentistry
RobertWick DDS

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Patient information

Patient' Name _____ What do you prefer to be called? _____

Sex: ◯Male ◯ Female Birthdate _____ ◯Single ◯Married Spouse's Name _____

How did you find out about our office? _____

If you are a student over age 18, name of school _____

ACCOUNT INFORMATION

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

Responsible Party _____ Social Security Number _____

Address _____ City_____ State_____ Zip _____

Home telephone _____ Cell telephone _____ Work telephone _____

E-Mail _____

Employed by _____ City _____State _____

If you do not have dental insurance, skip to "Dental History"

INSURANCE INFORMATION

Employee's Name _____ SSN _____ DOB _____

Employer_____ City_____ State_____ Zip _____

Insurance Carrier's Name _____ Group # _____ Union or Local _____

Address _____ City_____ State_____ Zip _____

Patient relationship to the employee ◯Self ◯ Spouse ◯ Child ◯ Other

ADDITIONAL COVERAGE

Employee's Name _____ SSN _____ DOB _____

Employer_____ City_____ State_____ Zip _____

Insurance Carrier's Name _____ Group # _____ Union or Local _____

Address _____ City_____ State_____ Zip _____

Patient relationship to the employee ◯Self ◯ Spouse ◯ Child ◯ Other

Dental History

Reason for seeking care today: ☐ Exam ☐ Cleaning ☐ Specific Problem _____

_____

How long since you have been to a dentist? _____

What was done then? _____

Please check all that apply:

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

_____

_____

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 anesthetic, 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:

- ☐ Previous injury to head or neck
- ☐ Heart Problem
- ☐ Heart attack
- ☐ Angina chest pain
- ☐ Heart Murmur
- ☐ Scarlet, Rheumatic Fever
- ☐ Mitral value prolapse
- ☐ Irregular Heartbeat
- ☐ High or low blood pressure
- ☐ Pacemaker
- ☐ Artificial joint
- ☐ Diabetes
- ☐ HIV or AIDS
- ☐ Kidney problem
- ☐ Liver Problem, Jaundice
- ☐ Cirrhosis, Hepatitis
- ☐ Cancer
- ☐ Radiation, Chemo
- ☐ Respiratory Problem
- ☐ Bloody, Persistent cough
- ☐ Asthma, Emphysema
- ☐ Anaemia
- ☐ Sickle cell
- ☐ Digestive problem, Ulcer
- ☐ Thyroid Disease
- ☐ Glaucoma
- ☐ Bleed or Bruise easily
- ☐ Stroke
- ☐ Epilepsy or Seizures
- ☐ Parkinson's
- ☐ Alzheimer's
- ☐ Back Problem
- ☐ Hives, Rash, Herpes
- ☐ Dry Eyes
- ☐ Contact Lenses
- ☐ Shortness of breath
- ☐ Snoring, Sleep Apnea
- ☐ Easily Winded
- ☐ No Energy
- ☐ Fainting or Dizzy
- ☐ Unexplained Weight Loss
- ☐ Chewing Tobacco
- ☐ Drug or Alcohol Addiction
- ☐ 2 or more social Drinks/Day
- ☐ Anxiety or Nervous Problem
- ☐ Insomnia, Depression
- ☐ Frustrated, Worried, Too Busy

Family history of

- ☐ Diabetes
- ☐ Heart Disease
- ☐ Other _____

Any other illnesses not checked above: _____

Would you prefer to speak privately with the dentist about a medical issue? ..... ◯ Yes ◯ No

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 anaesthesia entail risk 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

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