WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The more you communicate to us, the more effectively we can care for you.

1 ABOUT YOU

Today's Date: ______________________________

NAME ______________________________
LAST FIRST MI MR. MRS. MS DR.

I prefer to be called: ____________________ ❑ Male ❑ Female

Birthdate:____/____/____ SS#: ____________________

Home Address: ______________________________
APT/CONDO

____
CITY STATE ZIP

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Hm#: ____________________ Pager/Other #: ____________________

Wk#: ____________________ Ext: _______DL#: ______________

Employer: ______________________________

Employer's Address: ______________________________

How Long There? ____________ Occupation:____________________

Where & When are the best times to reach you? ____________________

Whom may we thank for referring you? ____________________

Other family members seen by us: ____________________

Previous / Present Dentist: ____________________

Last Visit Date: ______________________________

What are your hobbies and interests? ____________________

____

____

2 SPOUSE/PARENT

His/Her Name: ______________________________

Employer: ______________________________

Wk#: ____________________ Ext: _______DL#: ______________

Birthdate:_____/_____/_____ DL#: ____________________

Person responsible for account:____________________

Wk#: ____________________ Ext: _______Hm#: ______________

Billing Address: ______________________________

Relation: ____________________ SS#: ____________________

Employer: ____________________ DL#: ____________________

OFFICE USE ONLY

MEDICAL ALERTS

Major Medical Alert ❑ Yes ❑ No

Pre-Medication ❑ Yes ❑ No

Allergy ______________________________

3 DENTAL INSURANCE

PRIMARY DENTAL INSURANCE

Insurance Co. Name: ______________________________

Insurance Co. Address: ______________________________

Insurance Co. Phone #: (_____) ____________________

Group # (Plan, Local or Policy #): ____________________

Insured's Name:____________________Relation: ____________

Insured's Birthdate:____ / ____ / ____ Insured's SS#:____________

Insured's Employer: ______________________________

SECONDARY DENTAL INSURANCE

Insurance Co. Name: ______________________________

Insurance Co. Address: ______________________________

Insurance Co. Phone #: (_____) ____________________

Group # (Plan, Local or Policy #): ____________________

Insured's Name:____________________Relation: ____________

Insured's Birthdate:____ / ____ / ____ Insured's SS#:____________

Insured's Employer: ______________________________

4 DENTAL HISTORY

Why have you come to the dentist today? ____________________

____

Do you need pre-medicated with antibiotics before dental treatment? ❑ Yes ❑ No

Are you currently in pain? ❑ Yes ❑ No

Have you ever had a serious / difficult problem associated with any previous dental work? ❑ Yes ❑ No

Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ/TMD)? ❑ Yes ❑ No

Your current dental health is: ❑ Poor ❑ Fair ❑ Good

Do you like your smile? ❑ Yes ❑ No

Do your gums ever bleed? ❑ Yes ❑ No

How many times a week do you floss? ____________________

How many times a day do you brush? ____________________

Types of bristles? ❑ Hard ❑ Medium ❑ Soft

How fearful are you of visiting the dentist?

Very______________Average______________Not Very ____________

Are you interested in long-term dental care? ____________________

____

5 MEDICAL HISTORY

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name : ____________________

Phone #: (_____)______________ Date of last visit: ______________

Your current physical health is: ❑ Poor ❑ Fair ❑ Good

Are you currently under the care of a physician? ❑ Yes ❑ No

Please Explain: ____________________

Are you taking any prescription or over-the-counter drugs? ❑ Yes ❑ No

Please list each one: ____________________

For Women: Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No Week #:________

Are you nursing? ❑ Yes ❑ No

Have you ever had any of the following diseases or medical problems?

Y N Abnormal Bleeding
Y N Alcohol/Drug Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Bones/Joints/Valves
Y N Asthma
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Colitis
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Fever Blisters
Y N Frequent Headaches
Y N Glaucoma
Y N Hay Fever
Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery
Y N Hemophilia
Y N Hepatitis
Y N Herpes
Y N High Blood Pressure
Y N HIV+ / AIDS
Y N Hospitalized for Any Reason
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Mitral Valve Prolapse
Y N Pacemaker
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic/Scarlet Fever
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease
Y N Sinus Problems
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis (TB)
Y N Ulcers

Please list any medical condition(s) that you have ever had:

____

Are you allergic to any of the following?

Y N Aspirin
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Latex
Y N Penicillin
Y N Tetracycline
Y N Other
Y N Jewelry/Metals

Please list any other drugs that you are allergic to: ____________________

In the event of an emergency, we need the name of someone who lives near you that we can contact.

His /Her Name:______________________Relation: ________

Wk #: (____)____________________Hm #: (____) __________

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. I accept full responsibility for charges incurred as a result of dental treatment and agree to pay any legal fees or court costs associated with collecting any balance due.

Signature ____________________ Date

Payment is due in full at time of treatment unless prior arrangements have been approved.

!

Thank you for filling out this form completely. It will enable us to more effectively help you. If you have a question at any time, please ask us. We are happy to help.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Dr. Wayne P. Dunn & Associates

1412 Blizzard Drive
Parkersburg, WV 26101
(304) 424-6100

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I verbally reviewed the medical / dental information above with the patient named herein. Initials:__________ Date: ______________

Doctor's comments: ____________________

MEDICAL HISTORY UPDATE

1. Date:______________ Initial:__________
2. Date:______________ Initial:__________
3. Date:______________ Initial:__________
4. Date:______________ Initial:__________
5. Date:______________ Initial:__________
6. Date:______________ Initial:__________
7. Date:______________ Initial:__________
8. Date:______________ Initial:__________