

# WESTERVILLE DENTAL ASSOCIATES

## HEALTH HISTORY

Are you under a physician's care now?  Yes  No  N/A \_\_\_\_\_  
Have you ever been hospitalized or had a major operation?  Yes  No  N/A \_\_\_\_\_  
Have you ever had a serious head or neck injury?  Yes  No  N/A \_\_\_\_\_  
Are you taking any medications, pills, or drugs?  Yes  No  N/A (List) \_\_\_\_\_  
Do you take, or have you taken, Phen-Fen or Redux?  Yes  No  N/A Do you use tobacco?  Yes  No  N/A  
Are you on a special diet?  Yes  No  N/A Do you use controlled substances?  Yes  No  N/A  
Women: Are you  Pregnant/Trying to get pregnant?  Nursing?  Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics  Other \_\_\_\_\_

Name of Physician \_\_\_\_\_

Do you have, or have you had, any of the following?

<input type="checkbox"/> Aids/HIV Positive	<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Cold Sores/Fever Blisters	<input type="checkbox"/> Genital Herpes	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Shingles
<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Congenital Heart Disorder	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Anemia	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Angina	<input type="checkbox"/> Cortisone Medicine	<input type="checkbox"/> Heart Attack/Failure	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Spina Bifida
<input type="checkbox"/> Arthritis/Gout	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Murmur*	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Stomach/Intestinal Disease
<input type="checkbox"/> Artificial Heart Valve*	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Heart Pace Maker*	<input type="checkbox"/> Mitral Valve Prolapse*	<input type="checkbox"/> Stroke
<input type="checkbox"/> Artificial Joint*	<input type="checkbox"/> Easily Winded	<input type="checkbox"/> Heart Trouble/Disease	<input type="checkbox"/> Pain in Jaw Joints	<input type="checkbox"/> Swelling of Limbs
<input type="checkbox"/> Asthma	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Parathyroid Disease	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Hepatitis B or C	<input type="checkbox"/> Radiation Treatments	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Breathing Problem	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Herpes	<input type="checkbox"/> Recent Weight Loss	<input type="checkbox"/> Tumors or Growths
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Fainting Spells/Dizziness	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Renal Dialysis	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Cancer	<input type="checkbox"/> Frequent Cough	<input type="checkbox"/> Hives or Rash	<input type="checkbox"/> Rheumatic Fever*	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Frequent Diarrhea	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Rheumatism	<input type="checkbox"/> Yellow Jaundice

\*Condition may require medication

Information reviewed (initial/year) \_\_\_\_\_/08 \_\_\_\_\_/09 \_\_\_\_\_/10 \_\_\_\_\_/11 \_\_\_\_\_/12 \_\_\_\_\_/13 \_\_\_\_\_/14

## DENTAL HISTORY

TO HELP US SERVE YOU BETTER, PLEASE ANSWER THE FOLLOWING QUESTIONS:

Do you have specific dental problems or complaints? \_\_\_\_\_

When was your last dental visit? \_\_\_\_\_ What was done? \_\_\_\_\_

Do you get headaches often? \_\_\_\_\_ Do you notice clicking noises when opening or chewing? \_\_\_\_\_

Have you ever worn braces? \_\_\_\_\_ Have you ever had your bite adjusted? \_\_\_\_\_

Do your gums bleed? \_\_\_\_\_ Does food catch between your teeth? \_\_\_\_\_

Have you thought about whitening your teeth? \_\_\_\_\_ Do you prefer silver or white fillings? \_\_\_\_\_

Have you been told you have periodontal disease? \_\_\_\_\_ If yes, when? \_\_\_\_\_ What was done? \_\_\_\_\_

How do you feel about being here today? \_\_\_\_\_

Is there any other information we should know before we treat you? \_\_\_\_\_

I have accurately completed this form and I will notify this office of any changes in my medical or dental information.

Patient or Responsible Party \_\_\_\_\_

Date \_\_\_\_\_

NAME

PATIENT ID #

# WESTERVILLE DENTAL ASSOCIATES

## Patient information

Today's Date \_\_\_\_\_

Name \_\_\_\_\_ SSN \_\_\_\_\_

Sex (M/F) \_\_\_\_\_ Date of Birth \_\_\_\_\_ Marital Status (circle) \_\_\_\_\_ M S W D \_\_\_\_\_

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

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Other Number (to reach you during the day) \_\_\_\_\_

May we leave messages regarding your dental appointments at the above numbers? Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_ Other \_\_\_\_\_

Employer Name \_\_\_\_\_ Position \_\_\_\_\_

## Contact Information To whom may we speak about your dental concerns?

Name \_\_\_\_\_ Phone Number \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Phone Number \_\_\_\_\_ Relationship \_\_\_\_\_

## Dental Insurance Information

Policy Holder Name \_\_\_\_\_ SSN \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Address (if different from above) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Other Number (to reach you during the day) \_\_\_\_\_

Employer Name \_\_\_\_\_ Insurance Company \_\_\_\_\_ Group Number \_\_\_\_\_

## Who else is covered on this policy?

Name \_\_\_\_\_ SSN \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Name \_\_\_\_\_ SSN \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Name \_\_\_\_\_ SSN \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_

## Authorization and Release

I authorize Westerville Dental Associates and or his agents to perform diagnostic procedures and treatment as may be necessary for proper dental care of myself and/or my child/children.  
I authorize release of any information concerning my and/or my child/children's dental care, advice and treatment to another dentist.  
I authorize release of any information concerning my and/or my child/children's dental care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits.  
I hereby authorize payment of insurance benefits directly to Westerville Dental Associates.  
I understand that my dental insurance carrier may pay less than the actual bill for services.  
I understand I am financially responsible for payments in full of all accounts.  
By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid in whole or in part by my dental insurance.  
I attest to the accuracy of the information on this document.

Patient or Responsible Party \_\_\_\_\_ Date \_\_\_\_\_

Information Verified (initial/year) \_\_\_\_\_/08 \_\_\_\_\_/09 \_\_\_\_\_/10 \_\_\_\_\_/11 \_\_\_\_\_/12 \_\_\_\_\_/13 \_\_\_\_\_/14 \_\_\_\_\_/15