WILLOW LAKE
DENTAL

S M D W DP

Name (Last) (First) (Middle) Date of Birth Gender Marital Status Social Security #

Home Address (Street) (City) (State) (Zip Code) Home phone #

Name of Employer Work Phone # Cell Phone # E-mail

Text or Call

Custodial Parent Responsible for Account Preferred confirm method?

How did you hear about our office? _____

Reason for today's visit? _____

Approximate date of last dental visit: _____

What is your primary concern that you would like us to address first? _____

Name of previous dentist: _____ Location: _____

Please add anything you feel is important regarding your dental health: _____

_____

Have you ever had any serious problem associated with previous dental treatment? ☐ Yes ☐ No

If **yes**, please explain: _____

Do you prefer Nitrous Oxide (laughing gas) during dental procedures? ☐ Yes ☐ No

Do you clench or grind your jaws while sleeping or during the day? ☐ Yes ☐ No

Would you like to have whiter teeth? ☐ Yes ☐ No

Women

Are you pregnant? ☐ Yes ☐ No If yes, number of weeks: _____ Name of OB/GYN: _____

If **not**, are you planning a pregnancy in the near future? ☐ Yes ☐ No

Are you a nursing mother? ☐ Yes ☐ No Are you taking birth control? ☐ Yes ☐ No

Date of last medical health care exam: _____ What was this exam for? _____

Have you been hospitalized in the last 5 years? ☐ Yes ☐ No

If **yes**, reason why? _____

Are you currently receiving medical care? ☐ Yes ☐ No

If **yes**, what is the nature of care? _____

Are you taking any medication now? ☐ Yes ☐ No

If **yes**, please list the names of the medications and conditions for which they are taken:

1) _____ Taken for: _____

2) _____ Taken for: _____

3) _____ Taken for: _____

4) _____ Taken for: _____

5) _____ Taken for: _____

6) _____ Taken for: _____

7) _____ Taken for: _____

Are you taking any herbal or vitamin supplements? ☐ Yes ☐ No

If **yes**, which ones? _____

Please list all the Names and Phone Numbers of the physicians who are currently providing you care:

1) _____

2) _____

Have you ever been told you need an antibiotic premedication before dental work? ☐ Yes ☐ No

Have you ever been treated with Bisphosphonate drugs or other drugs to treat osteoporosis? ☐ Yes ☐ No

If **yes** when did treatment begin? _____ When did treatment end? _____

Do you consume grapefruit juice, grapefruits or grapefruit extract? ☐ Yes ☐ No

Do you take Antacids? ☐ Yes ☐ No If **yes**, how often? _____

Do you smoke or use tobacco? ☐ Yes ☐ No If **yes**, how often? _____

Do you consume alcohol? ☐ Yes ☐ No If **yes**, how often? _____

Do you use recreational drugs? ☐ Yes ☐ No If **yes**, how often? _____

Height: _____ Weight: _____

Please indicate whether or not you are **allergic** to the following:

Aspirin/Ibuprofen (Advil)	☐ Yes	☐ No	Latex	☐ Yes	☐ No
Benzodiazepines (ex. Valium)	☐ Yes	☐ No	Metals	☐ Yes	☐ No
Codeine	☐ Yes	☐ No	Penicillin	☐ Yes	☐ No
Local Anesthetics	☐ Yes	☐ No	Sulfa	☐ Yes	☐ No
Erythromycin	☐ Yes	☐ No	Tetracycline	☐ Yes	☐ No
Jewelry	☐ Yes	☐ No	Other:		

Have you ever had (please check/mark yes or no for each of the following):

Abnormal Bleeding	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Allergies	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No
If **yes**, what type:			Irregular Heartbeat	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Joint Replacement/Artificial Joint	☐ Yes	☐ No
Angina Pectoris	☐ Yes	☐ No	If **yes**, what type:		
Arthritis	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Kidney Dialysis	☐ Yes	☐ No
Autoimmune Disorder	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
If **yes**, what type:			Low Blood Pressure	☐ Yes	☐ No
Bleeding Disorder	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Organ Transplant	☐ Yes	☐ No
If **yes**, what type:			If **yes**, what type and when:		
Chemical Dependency	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No
If **yes**, what type:			Osteoporosis	☐ Yes	☐ No
Colitis	☐ Yes	☐ No	Previous Biopsies	☐ Yes	☐ No
Congenital Heart Defect/Disease	☐ Yes	☐ No	If **yes**, what type:		
Congestive Heart Failure	☐ Yes	☐ No	Psychiatric Problem/Treatment	☐ Yes	☐ No
Chronic Obstructive Pulmonary Disease	☐ Yes	☐ No	Radiation Therapy/Chemotherapy	☐ Yes	☐ No
Coumadin or other blood thinner	☐ Yes	☐ No	Recurrent Illness	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Sexually Transmitted Disease	☐ Yes	☐ No
Difficulty Breathing	☐ Yes	☐ No	Sleep Apnea	☐ Yes	☐ No
Eating Disorder	☐ Yes	☐ No	Slow-Healing Mouth Sores	☐ Yes	☐ No
Emphysema/Respiratory Illnesses	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Stomach Disorder	☐ Yes	☐ No
Fainting Spells	☐ Yes	☐ No	Thyroid Disorder	☐ Yes	☐ No
HIV/AIDS or ARC	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No	Other:		
Heart Disease	☐ Yes	☐ No			
Heart Surgery	☐ Yes	☐ No			
Heart Valve Replacement	☐ Yes	☐ No			
Hemophilia	☐ Yes	☐ No			
Hepatitis	☐ Yes	☐ No			

Emergency Contact

Name: _____ Relationship: _____

Phone Number : _____

Do you have Dental Insurance? ☐ Yes ☐ No **Dental Insurance** (Please Provide Insurance Card)

Policy Holder: _____ Policy Holder's Date of Birth: _____

ID Number: _____ Group Number: _____

Employer: _____ Group Name: _____

I certify that I have read and understand the preceding pages and that the information provided is complete and accurate. I understand that payment is my obligation regardless of insurance or any third party involvement. I understand the above information is necessary to provide me with dental care in a safe and efficient manner. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify Willow Lake Dental of all changes in my health and medications.

Signature: _____ Date: _____