Waldorf Cosmetic and Implant Dentistry

Patient Information

Name: ☐Mr. ☐Mrs. ☐Ms. ☐Dr. _____Male ☐ Female☐
☐Single ☐Married Birth date:_____Social Security #:_____

Home address: _____City:_____State: ____Zip:_____
Home phone: _____Mobile phone:_____ Email:_____

Employer: _____Business phone:_____
Business address: _____ City: _____State: ____Zip:_____

Whom may we thank for referring you to our office?_____
Where do you prefer to be contacted? ☐ Home ☐Cellular ☐Business ☐Email

DENTAL INSURANCE INFORMATION

Name of insured person: _____Relationship to patient:_____
Birth date: _____
Employer:_____Business phone:_____
Insurance Co. name: _____Phone: _____Group #:_____

ADDITIONAL DENTAL INSURANCE INFORMATION

Name of insured person: _____Relationship to patient:_____
Birth date:_____
Employer: _____Business phone:_____
Insurance Co. name: _____Phone: _____Group #:_____

RESPONSIBLE PARTY

Name of person responsible for payment:_____ Relationship to patient:_____

If the person responsible for payment is someone other than the patient, please complete the section below so that we have the appropriate billing information for your account.

Is the person responsible for payment currently a patient in our office? Yes ❑No ❑
Home address:_____City: _____State:____ Zip:_____
Home phone: _____Mobile phone:_____ Email:_____
Employer: _____Business phone:_____
Business address: _____City:_____ State: ____Zip:_____

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Patient Information

Patient name:_____Birthdate:_____
Physician name: _____Physician phone:_____

Do you take any medications?
Yes ❑No ❑If yes, please list all medications and the reason why you are taking them.

_____

Do you smoke cigarettes or use smokeless tobacco? Yes ❑ No ❑
Have you ever taken oral or intravenous bisphosphonate drugs for osteoporosis, metastatic cancer, or other conditions? Examples of bisphosphonates are alendronate (Fosamax®), risedronate (Actonel®), pamidronate (Aredia®) and zoledronate (Zometa®).
Yes ❑No ❑

Are you allergic to any of the following?

Yes	No		Yes	No		Yes	No	
❑	❑	Penicillin	❑	❑	Sulfa Drugs	❑	❑	Other Allergies (if yes, explain)
❑	❑	Local anesthetics	❑	❑	Latex			_____

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

Yes	No		Yes	No	
❑	❑	Alcohol or drug addiction	❑	❑	High Blood Pressure
❑	❑	Anemia	❑	❑	HIV or AIDS
❑	❑	Artificial joint replacement (hip, knee, etc.)	❑	❑	Kidney problems
❑	❑	Artificial heart valve	❑	❑	Liver problems
❑	❑	Asthma	❑	❑	Lung problems
❑	❑	Cancer	❑	❑	Psychiatric care
❑	❑	Congenital heart defect	❑	❑	Respiratory problems
❑	❑	Corticosteroid treatment	❑	❑	Radiation treatment
❑	❑	Dental phobia or anxiety	❑	❑	Rheumatic fever
❑	❑	Diabetes	❑	❑	Sinus problems
❑	❑	Epilepsy or seizures	❑	❑	Stomach or intestinal problems
❑	❑	Excessive bleeding	❑	❑	Stroke
❑	❑	Fainting spells or dizziness	❑	❑	Thyroid problems
❑	❑	Heart murmur	❑	❑	Tuberculosis
❑	❑	Heart pacemaker	❑	❑	Tumors or growths
❑	❑	Heart attack or heart problems	❑	❑	Other health problems
❑	❑	Hepatitis	❑	❑	If female, are you pregnant?
❑	❑	Herpes or cold sores	❑	❑	If female, do you take birth control pills?

Please provide additional information for all "yes" responses:

_____

Signature: _____Date:_____

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Dental History

Patient name:_____

What is the reason for your dental visit today?_____

_____

_____

Do you currently have any teeth that are sensitive?
Yes ❑No ❑If yes, please explain._____

_____

When was the last time you saw a dentist?_____

When was your last professional cleaning?_____

How often do you brush your teeth?_____

How often do you floss your teeth?_____

	Yes	No
Have you ever been treated for periodontal disease (gum disease)?	☐	☐
Do you feel that you can chew well with your teeth?	☐	☐
Do you grind or clench your teeth?	☐	☐
Do you ever have jaw pain or jaw muscle soreness?	☐	☐
Have you ever worn a nightguard or been told that you should?	☐	☐
Do you like the way your smile looks?	☐	☐
Do you like the color of your teeth?	☐	☐
Do you have any teeth or restorations that you are unhappy with?	☐	☐
Would you like to discuss esthetic improvements that can be made to your smile?	☐	☐