Way Family Dentistry
Comfort & Technology

1. Patient Information

Name_____
First Last MI
Preferred Name _____**Title**_____
☐ Male ☐ Female ☐ Child ☐ Single ☐ Married ☐ Other

Date of Birth_____ **SSN**_____
Driver's Lic._____ **State**_____
(Photocopy required)
Address _____
City_____**State**_____**Zip Code**_____
Home Phone _____ **Alternate Phone** _____
E-mail _____ **Alternate E-mail** _____

Occupation_____
Employer_____ **Work Phone**_____
Emergency Contact Name/Phone_____
How did you hear about us?_____

2. Insurance Information

Insured Employee_____ **Insured's Relationship to Patient**_____

Insured's SSN_____**DOB**_____

Insurance Company_____ **Phone**_____

Employer_____**Group #**_____

Is the patient covered by additional insurance? ☐ Yes ☐ No

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above insurance company and assign directly to this office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize this office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____

Relationship to Patient **Date**

3.Dental History

Circle "Yes" or "No" to indicate whether you have had any of the following conditions:

Reason for today's visit_____

Former Dentist_____

Phone_____

Date of last dental exam_____

Date of last dental x-rays_____

Date of last cleaning_____

How often do you brush?_____

How often do you floss?_____

Do you feel pain anywhere?_____

Describe_____

_____

Sensitivity to hot or cold	**Yes**	**No**	Bad breath	**Yes**	**No**
Sensitivity to sweet	**Yes**	**No**	Burning sensation on tongue	**Yes**	**No**
Avoid one side of the mouth when chewing	**Yes**	**No**	Dry mouth	**Yes**	**No**
Sensitivity when biting	**Yes**	**No**	Accident involving jaw	**Yes**	**No**
Broken / cracked fillings	**Yes**	**No**	Clicking or popping jaw	**Yes**	**No**
Food collection between teeth	**Yes**	**No**	Frequent headaches	**Yes**	**No**
Tobacco use	**Yes**	**No**	Grinding teeth	**Yes**	**No**
Gums swollen or tender	**Yes**	**No**	Jaw pain or tiredness	**Yes**	**No**
Gums bleed frequently	**Yes**	**No**	Pain around ear	**Yes**	**No**
Blisters on lips or mouth	**Yes**	**No**	Orthodontic treatment	**Yes**	**No**
Sores or growths inside cheek/in the mouth	**Yes**	**No**	Periodontal treatment	**Yes**	**No**

4. Medical Health History

Physician Name _____ Phone_____

Please list all current medications (include prescription, over-the-counter, herbal supplements) and reason for use:

_____

Are you allergic to the following:

Aspirin Yes No **Erythromycin** Yes No **Tetracycline** Yes No **Codeine** Yes No **Latex** Yes No **Penicillin** Yes No

Please list any other drugs/materials that you are allergic to: _____

Have you had any of the following conditions? ☐ **Artificial joint/valve** ☐ **Heart murmur** ☐ **Mitral valve prolapse** ☐ **Rheumatic fever**

Women Only: Do you use birth control medication? **Yes No** Are you nursing? **Yes No** Are you pregnant? **Yes No** (Due date:_____)

Circle "Yes" or "No" to indicate whether you have had any of the following conditions:

AIDS / HIV	**Yes**	**No**	Convulsions / Epilepsy / Seizures	**Yes**	**No**	Phen-Phen treatment	**Yes**	**No**
Anemia	**Yes**	**No**	Diabetes	**Yes**	**No**	Radiation or Chemotherapy treatment	**Yes**	**No**
Arthritis or Back problems	**Yes**	**No**	Excessive bleeding with surgery/extractions	**Yes**	**No**	Stroke	**Yes**	**No**
Asthma or Respiratory problems	**Yes**	**No**	Heart problems	**Yes**	**No**	Thyroid disorder	**Yes**	**No**
Blood transfusion (Date:_____)	**Yes**	**No**	Hepatitis or Liver problems	**Yes**	**No**	Tuberculosis	**Yes**	**No**
Cancer	**Yes**	**No**	High or Low blood pressure	**Yes**	**No**	Other:	**Yes**	**No**
Cardiac pacemaker	**Yes**	**No**	Kidney problems	**Yes**	**No**			

I, the undersigned, certify that the above questions have been accurately answered to the best of my knowledge. I understand that providing incorrect information about my medical or dental history can be dangerous to my health.

_____ _____

X Responsible Party Signature Date

_____ _____

X Attending Dentist Signature Date