Westend smiles

WELCOME TO OUR CLINIC! The following information is required to enable us to provide you with the best possible dental care. All information is strictly private and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

Date: _____/_____/_____ Medical Alerts: _____
Day Month Year (for office use only)

PERSONAL INFORMATION

Patient Name: _____

Date of Birth: _____/_____/_____ Age: _____
Day Month Year

Address: _____Postal Code:_____

Email Address: _____ Best Contact Number_____

In case of an emergency contact :

_____

Medical Doctor: _____
Phone:_____

Pharmacy Name: _____ Phone: _____
Fax:_____

Insurance Company Name: _____ Subscriber's Name:_____

Subscriber's Birthdate:_____ Address (if diff than above)_____

ID No.: _____ Policy No.:

_____

Secondary Ins Company Name: _____ Subscriber's Birthdate:_____

Subscriber's Name:_____ Address (if diff from above):_____

ID No.: _____ Policy No.:

_____

Who may we thank for referring you?

_____

OFFICE POLICY: Your appointment is reserved especially for you. If you are unable to keep the appointment we will require 48 hours notice otherwise it may be necessary to charge for the lost time.

I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers regarding my medical-dental history. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I also understand that consultation with my medical doctor, insurance provider or pharmacist may be required and authorize the dentist and his staff to do so. I understand that payment for all dental services is my responsibility even if I have insurance benefits.

MEDICAL HISTORY

1. Have you ever had a serious illness requiring hospitalization or extensive medical care? o Yes o No

If yes, please explain;

_____
_____
_____
_____

2. When was your last medical checkup?

   _____

Any change in your general health? o Yes o No If yes, please explain:

_____
_____

3. Do you have any allergies? If you answer yes, please list using the categories below: o Yes o No

a. Medications:

_____

b. Other (eg. Hay fever, foods):

_____

4. Are you taking any medication, non-prescription drugs, or herbal supplements of any kind?

If yes, please list. (e.g. birth control pills, vitamins, homeopathic, warfarin, aspirin)

Medication	Frequency	Dose	Condition it Treats

5. Have you ever had a peculiar reaction to any medicine or injection? o Yes o No If yes, please explain

_____

6. Do you or have you ever had problems with any of the following? Please check all that apply:

o Stroke o Kidney disease o Osteoporosis medications (eg. Fosamax, Actonel) or Bone cancer

o Rheumatic fever o Heart murmur o Thyroid disease o Heart Attack o Tuberculosis o Arthritis

o Drug/alcohol dependency o Sinus/Middle ear problems o Cancer o Pacemaker o Asthma/Lung Disease

o Auto Immune Disorders o Surgery (please explain) o Blood clotting, abnormal bleeding

o Liver disease o High/Low blood pressure o Prosthetic, artificial joint oEpilepsy/Seizures

oMental Health oGlaucoma/Vision Problems oHepatitis A,B,C oArthritis/Rheumatism oHeart Valve Repair

7. Are there any conditions or diseases not listed that you have now or had in the past? o Yes o No

If yes, please
list:_____

_____

_____

_____

_____

8. Are there any diseases or medical conditions that run in your family? (e.g. cancer, diabetes, heart disease, etc.) o Yes o No If yes, please list below:

_____

_____

9. Do you smoke, vape or chew tobacco products? o Yes o No If yes, Frequency? _____

10. Are you pregnant or breast feeding? o Yes o No

DENTAL HISTORY

1. How frequently do you see a dentist or hygienist? o 6 months o Yearly o Other: _____

2. When was your last dental visit? _____ Last X-Rays?

_____

3. Who was your last dentist? _____ Office Name:

_____

3. How often do you brush your teeth? _____ Floss?

_____

4. Are your teeth sensitive to: o Hot o Cold o Sweets o Chewing

5. Do your gums bleed when: o Brushing o Flossing o Never

6. Do your gums feel swollen and tender? o Yes o No

7. Do you feel you have bad breath or bad taste in mouth? o Yes o No

8. Does your jaw pop or crack when opening widely? o Yes o No

9. Do you grind or clench your teeth? o Yes o No

10. Do you have food catch between your teeth? o Yes o No

11. Have you ever had any problems with previous dental treatments? o Yes o No

12. Are you satisfied with your teeth? o Yes o No

13. Have you been diagnosed with sleep apnea? o Yes o No

14. Do you have any specific requests to make your visits more comfortable?

_____
_____

15. Would you like to discuss any of the following?

o Orthodontics/Invisalign o Cosmetic Dentistry o Gum Graft treatment

o Whitening o Implants o Migraines & Botox Treatment

16. Is there anything else you would like to mention to the dentist that has not been covered on this form?

_____
_____

_____
_____

To the best of my knowledge, the above information is correct.

Patient/Parent/Guardian Signature: _____ Date:
_____

Dentist Signature: _____ Date:
_____