

# Windham Dental Center Welcomes You

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## Patient Information

Name \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_

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

Home Phone \_\_\_\_\_ Work # \_\_\_\_\_ Cell# \_\_\_\_\_

Email Address: \_\_\_\_\_

Circle Appropriate: Single   Married   Divorced   Widowed   Child   Full-time Student? Y or N

If F-T Student: Name of College, Including City and State: \_\_\_\_\_

Patient/Guardian Employer \_\_\_\_\_ Address \_\_\_\_\_

Occupation \_\_\_\_\_ How Did You Hear About Our Office? \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

## Dental History

Previous Dentist \_\_\_\_\_ Address \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Date of Last X-Rays: Full Mouth: \_\_\_\_\_ Bitewings: \_\_\_\_\_

NOTE: If possible, please obtain a copy of the most recent x-rays and bring them with you to your first visit, or have the dentist send them directly to Windham Dental Center. Thank you.

## Dental Insurance Information

*(We will need to make a copy of your insurance ID Card)*

Name of Policy Holder \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

DOB \_\_\_\_\_ SS# \_\_\_\_\_ Date Employed \_\_\_\_\_

Policy Holder Employer \_\_\_\_\_ Work # \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group# \_\_\_\_\_

Ins.Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Over Please

## Patient Medical History

Physician \_\_\_\_\_ Office Phone \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

1. Are you Under Medical Treatment now? Y or N

2. Have you ever been hospitalized for any operation/surgery in the last 5 years? Y or N

If yes, please explain: \_\_\_\_\_

3. Are you taking any medication(s) including over the counter? Y or N

If yes, what medications? \_\_\_\_\_  
 \_\_\_\_\_

4. Do you use Tobacco? Y or N

5. Do you use controlled substances? Y or N

6. Do you have or have you had any of the following?

Aids/HIV	Y or N	Glaucoma	Y or N	Liver Disease	Y or N
Anemia	Y or N	Hay Fever	Y or N	Low Blood Pressure	Y or N
Angina	Y or N	Heart Attack	Y or N	Mitral Valve Prolapse**	Y or N
Arthritis	Y or N	Heart Disease	Y or N	Pacemaker	Y or N
Asthma	Y or N	Heart Murmur**	Y or N	Radiation TX	Y or N
Cancer	Y or N	Heart Trouble	Y or N	Rheumatic Fever	Y or N
Chest Pains	Y or N	Hepatitis	Y or N	Stroke	Y or N
Diabetes	Y or N	High Blood Pressure	Y or N	Thyroid Problems	Y or N
Emphysema	Y or N	Joint Replacement**	Y or N	Tuberculosis	Y or N
Epilepsy/Convulsions	Y or N	Kidney Disease	Y or N	Weight Loss (Recent)	Y or N
Fainting/Seizures	Y or N	Leukemia	Y or N		

\*\* If you answered yes to any of these conditions, do you need to pre-medicate prior to dental visits Y or N

If yes, name of medication: \_\_\_\_\_

7. Are you allergic to or have you had any reaction to the following?

Aspirin Y or N

Barbiturates Y or N

Iodine Y or N

Latex Y or N

Local Anesthetics (e.g. Novocain) Y or N

Metals (e.g. nickel, mercury, etc.) Y or N

Penicillin or any other Antibiotic Y or N

Sedatives Y or N

Sulfa Drugs Y or N

Other: \_\_\_\_\_

**8. WOMEN ONLY:**

Are you pregnant or think you may be pregnant? Y or N

Are you nursing? Y or N

Are you taking oral contraceptives? Y or N

**DENTAL HISTORY:**

1. Do your gums bleed easily? Y or N

6. Do you have frequent headaches? Y or N

2. Are your teeth sensitive to hot, cold or sweets? Y or N

7. Do you clench or grind your teeth? Y or N

3. Do you have any pain in your teeth? Y or N

8. Have you had orthodontics? Y or N

9. Do you wear a denture/partial Y or N

4. Have you ever had prolonged bleeding after an extraction? Y or N

10. Have you received oral hygiene instructions regarding your gums? Y or N

11. Do you like your smile? Y or N

5. Have you ever experienced any of the following problems?  
 Jaw Clicking Y or N      Jaw Pain Y or N      Difficulty Opening Y or N

X \_\_\_\_\_ Date \_\_\_\_\_  
 Patient Signature/Legal Guardian