

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

4. Have you ever had prolonged bleeding after an extraction? Y or N 9. Do you wear a denture/partial Y or N

5. Have you ever experienced any of the following problems? Y or N 10. Have you received oral hygiene instructions regarding your gums? Y or N

Jaw Clicking Y or N 11. Do you like your smile? Y or N

Jaw Pain Y or N Difficulty Opening Y or N

X _____ Date _____

Patient Signature/Legal Guardian