

William B. Wynn, IV, D.D.S., M.S.

**SUITE 1008 • KELLY PROFESSIONAL BUILDING
6565 SOUTH YALE AVENUE
TULSA, OKLAHOMA 74136**

Practice Limited to Periodontics

TELEPHONE: (918) 492-0737

REGISTRATION

Date _____

Patient's Name _____ Age _____

Single _____ Married _____ Separated _____ Divorced _____ Widowed _____ Minor _____

Date of Birth _____ Social Security No. _____

Name of Spouse _____

If a Child, Parent's Name _____

Residence Address _____

City _____ State _____ Zip Code _____

Telephone: Residence _____ Cell _____ Business _____

Employed By _____

Business Address _____

Spouse Employed By _____ Business Tel. # _____

Spouse Date of Birth _____ Spouse Social Security No. _____

Whom may we thank for referring you? _____

Nearest relative not living with you _____
(name, address, phone no.)

Person Responsible for Payment of Account _____
(and address if different than above)

Name of Dental Insurance Company _____

HEALTH QUESTIONNAIRE

Answers to the following questions are for our records and will be considered *confidential*.

1. Are you presently under the care of a physician? Yes No
 If so, for what condition are you being treated?

Name and address of physician _____

Phone _____

2. Is your general health good? Yes No
 3. Have you ever been hospitalized or had a serious illness? Yes No
 4. Have you had abnormal bleeding associated with previous extractions, surgery or trauma? Yes No
 a. Do you bruise easily? Yes No
 b. Have you ever required a blood transfusion? Yes No
 If so, explain the circumstances.

5. Are you allergic or have you reacted adversely to:
 a. Local anesthetics (Novocaine)? Yes No
 b. Penicillin or other antibiotics? Yes No
 c. Barbiturates, sedatives, sleeping pills? Yes No

- d. Aspirin? Yes No
 e. Codeine or other narcotics? Yes No
 f. Nitrous oxide analgesia? Yes No
 g. Have you had an unpleasant experience with ether or any gas administered to you? Yes No

6. Have you had any trouble with previous dental work? Yes No

Please explain _____

7. Do you take any dietary supplements such as vitamins or proteins? Yes No
 8. Do you consider yourself a nervous or tense person? Yes No
 9. Have you ever had a malignant or non-malignant tumor removed? Yes No
 10. Have you ever had a biopsy? Yes No
 11. Do you wear a pacemaker? Yes No
 12. Have you ever tested positive for AIDS, HIV, ARC or Aids Related Complex? Yes No
 13. Do any blood relatives have diabetes? Yes No
 14. Do you take aspirin regularly? Yes No
 15. Are you "At Risk" for AIDS or HIV? Yes No
 16. Have you abused alcohol or drugs? Yes No

Do you or have you ever had:

- | | | |
|--|---|--|
| Heart trouble? Yes No | Anemia? Yes No | Jaundice? Yes No |
| Pain in Chest? Yes No | Epilepsy or Convulsions? Yes No | Hepatitis? Yes No |
| Shortness of breath? Yes No | Glaucoma? Yes No | Prolonged bleeding? Yes No |
| Swollen ankles? Yes No | Thyroid trouble? Yes No | Stomach Trouble? Yes No |
| Rheumatic Fever? Yes No | Goiter? Yes No | Venereal Disease? Yes No |
| Heart Murmur? Yes No | Low Blood pressure? Yes No | Arthritis? Yes No |
| Fainting or Dizziness? Yes No | Persistent cough? Yes No | Measles? Yes No |
| Stroke? Yes No | Hayfever or Asthma? Yes No | Tumor? Yes No |
| High blood pressure? Yes No | Tuberculosis? Yes No | Eczema or Hives? Yes No |
| Diabetes? Yes No | Kidney or bladder trouble? Yes No | Frequent Headaches? Yes No |
| Bad nose bleeds? Yes No | Neurosis or psychological problems? Yes No | Cancer? Yes No |
| Rheumatic heart disease? Yes No | | Have you ever taken Phen-Fen or other dietary drugs? Yes No |

Have you ever taken:

Aspirin?	Yes	No	Nitroglycerin?	Yes	No	Tranquilizers or Sedative?	Yes	No
Drugs for sleep?	Yes	No	Drugs for high blood pressure?	Yes	No	Insulin or Orinase?	Yes	No
Anticoagulants?	Yes	No	Cortisone, steroids, ACTH?	Yes	No	Digitalis or Drugs for heart trouble?	Yes	No
Antibiotics?	Yes	No	Sulfa Drugs?	Yes	No	Penicillin?	Yes	No

What medications have you taken in the past year? _____

Please list any hospitalizations and dates _____

Do you have any condition, problem, or disease, not mentioned above?

Please explain _____

Women

- 1. Are you pregnant? Yes No
- 2. Are you presently taking birth control pills? Yes No

I hereby authorize payment of the insurance benefits otherwise payable to me to, directly to William B. Wynn, D.D.S., Inc. but not to exceed the charges shown. I understand that I am financially responsible for any charges not covered by my insurance carrier. I also authorize Dr. William B. Wynn to release any information acquired in the course of the examination to my insurance carrier. I authorize Dr. William B. Wynn to consult with my physician regarding medical conditions, if necessary.

Signed _____ Date _____ S. S. # _____

Pulse _____ Blood Pressure _____

COMMENTS:

Please complete reverse side

Why are you here _____

Do your parents or siblings have their natural teeth? _____

Who is your general dentist? _____ For How Long? _____

When were your teeth last cleaned? _____

Are you currently experiencing pain from your mouth? Yes No
Have you ever had periodontal treatment? Yes No
Has periodontal disease been found in your mouth before? Yes No
Have you completed any recent dental procedures? Yes No

What? _____

Do you fear dental treatment? Yes No
Have you had any teeth extracted recently? Yes No
Can you chew satisfactorily? Yes No
Have you had many cavities? Yes No
Are you satisfied with the appearance of your teeth? Yes No
Have you ever had trench mouth? Yes No
Are you embarrassed by bad breath? Yes No
Have you noticed any bad oral odors or taste? Yes No
Have you ever had a tooth or gum abscess? Yes No
Are your teeth sensitive to hot or cold drinks, sweets, chewing, or touch? Yes No
Have you noticed any rough sharp or uneven fillings? Yes No
Does food catch or wedge between your teeth? Yes No
Have you noticed bleeding during brushing, flossing, or eating? Yes No
Do you have any loose teeth? Yes No
Are your gums receding? Yes No
Have you noticed itching or other sensations in your gums? Yes No
Do your teeth come together unevenly? Yes No
Do you ever awaken with "tightness" or pain in the jaw joints? Yes No
Do your jaw joints hurt after eating, talking, yawning, or after a long day? Yes No

Do your jaw joints pop or click? Yes No
Do you clench or grind your teeth at night or during the day? Yes No
Have you noticed your bite changing or any teeth moving? Yes No
Have you noticed increasing spaces between teeth? Yes No
Do you smoke? Yes No
Do you take vitamins or diet supplements? Yes No
Do you have an imbalanced or irregular diet? Yes No
Do you dislike or avoid citrus fruits, yellow and green vegetables or salads? Yes No
Are you frequently dieting? Yes No
Do you frequently eat at fast food restaurants? Yes No
Do you eat many sweets? Yes No
Do you use breath mints, "Lifesavers", "Clorets", "Certs", "Tic Tacs", chewing gum or hard candies? Yes No
Do you drink colas, coffee, or tea with sugar? Yes No
Do you regularly eat breakfast cereal or pastries? Yes No
Do you regularly use "Tums", "Rolaids" or other antacids? Yes No

Please note any items you use in your mouth care and frequency:

- () Tooth brush
- () Floss
- () Water Spray device
- () Toothpicks
- () Proxabrush
- () Stimulents
- () Rubber tip
- () Mouthwashes
- () Electric toothbrush
- () Other

Do you wake up with a dry mouth or lips? Yes No
Have you experienced a burning sensation of the tongue? Yes No
Are your teeth affecting your general health in any way? Yes No