Donald E. Walter, D.D.S.

Medical Alert

CONFIDENTIAL PATIENT INFORMATION AND HEALTH HISTORY

Date______________

Name____
Last First Middle

Street____________________________________City______________________________
State Zip

Date of Birth______________Home Phone #.______________Cell Phone#_____________

Social Sec. #_____________________Sex ___M ___ F Height_______ Weight_______

Occupation_____________________ Employer________________work #____________

What is the patient's preferred name? ___________Email_________________________

__ Single __Divorced __Widowed __ Married Spouse______________________

Spouse's Occupation_____________ Employer________________ Work #___________

Closest Relative_____________________________ Phone number__________________

Do you have dental insurance? __ Yes __ No **Subscriber's Name**__________________

Subscriber's SSN ______________**Sub.Date of Birth**__________**Employer**_________

Insurance Company Name____

Address ____

Phone Number_________________________________ Group/Policy #____________

In the following questions, circle Yes or No, whichever applies.

	Do you have a Health Problem?	YES	NO
	If yes, what? ______________________________		
1.	The name of my Physician is ______________________		
2.	My last Physical Exam was on ______________________		
3.	Have you been under treatment by a physician recently?	YES	NO
	If yes, for what? ______________________________		
4.	Are you taking any drugs or medication?	YES	NO
	If yes, what kinds? ______________________________		
5.	Have you ever reacted adversely to:		
	a. Local Anesthetics	YES	NO
	b. Penicillin or Other Antibiotics	YES	NO
	c. Sulfa Drugs	YES	NO
	d. Barbiturates, Sedatives, Sleeping Pills	YES	NO
	e. Aspirin	YES	NO
	f. Codeine or Other Narcotics	YES	NO
	If yes, what kind of reaction? ______________________		

6. Are you allergic to anything? YES NO
If yes, what? ____

7. Do you have any emotional, mental or nervous problems? YES NO
If yes, which?____

8. Do you have or have you ever had Hepatitis? YES NO

9. Do you bleed a great deal after a tooth extraction or cut? YES NO

10. Have you ever-tested HIV Positive? YES NO

11. Have you ever had any problems with any of the following? (Check all that apply)

__Heart __Kidney __Tuberculosis __HIV (+) __Ulcers
__Anemia __Liver __Rheumatic Fever __Headache __Cough
__Leukemia __Fainting __Epilepsy (Seizures) __Speech __Dizziness
__Freq. Colds __ Arthritis __Recent weight loss __Sinus __Diabetes
__Hepatitis __ Stroke __Blood Pressure __Blood disorder
__ Asthma __Venereal Disease __Joint Replacement

WOMEN

12. Are you pregnant? ___________ Months YES NO

13. Do you have any problems associated with your menstrual period? YES NO

14. Are you using Oral Contraceptives (Birth Control)? YES NO

DENTAL HISTORY

15. Is this your first visit to a dentist? YES NO
If not, when was your last dental exam?___________ Last x-rays________________
Date of your last prophylaxis? (cleaning) ________________________________

16. Do you have any problems with any of the following? (Check all that apply)

__Recent toothache __Swelling or lumps in mouth __Clenching or Grinding __Mouth Breathing
__Food Impaction __Orthodontic Treatment __Pain around ear __Bad Breath
__Burning of tongue __Periodontal Disease __Spaces Developing Btw. Teeth
__Sensitive Teeth __ Freq. Blisters on Lips/mouth __Complications from Extractions
__Bleeding gums? How long? ________________ __Other concerns? ____________________

17. Do you use any of the following? (Check all that apply)

__Chewing tobacco __ Dental Floss Toothbrush- texture? ______________
__Water Jet Device __Fluoride Sup. Frequency of Brushing?____________
__Other Hygiene Aids __Inter-Dental Stimulators __Cigarettes, Pipe or Cigars

18. Are you wearing any removable dental appliances? YES NO

19. Have you ever bumped your teeth? YES NO

20. Have you had any serious complications associated with
Any previous dental treatment? YES NO

21. Who may we thank for referring you? _________________________

COMMENTS:

___________________________________ ___________________________________

Signature of Patient **Signature of Parent if Patient Under 18**