# Mark W. Nester, D.M.D.
# Keith G. Wyckoff, D.M.D.
# Carl K. Wyckoff, III, D.D.S.

Patient's Name: ______________________
(Mr., Mrs., Ms., Dr.)

Preferred Name: ______________________

Responsible Party: ______________________

Address: ______________________

City: ____________ State: ______ Zip: ______

Tel: (H) ________ (W)________ (Cell #) ________

Date of Birth: ________ S.S. #: ________

Employer: ______________________

E-mail: ______________________

Dental Ins. Co.: ______________________

Subscriber: ________ Employer: ________

S.S. #: ________ Date of Birth: ________

ID #: ________ Group #: ________

2nd Dental Ins. Co.: ______________________

Subscriber: ________ Employer: ________

S.S. #: ________ Date of Birth: ________

ID #: ________ Group #: ________

Referred by: ______________________

## MEDICAL HISTORY

Although dental personnel primarily treat the areas in and around the mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

1. My last physical examination was on: ______________________

   My last dental examination was on: ______________________

2. The name and address of my physician is Dr.: ________________ Phone No.: ________

   ______________________________________________

3. Are you now under the care of a physician? ________ Yes No
4. Have you had any operations or been hospitalized for any serious illness? ________ Yes No
5. Are you pregnant or are you trying to become pregnant? ________ Yes No
6. Are you now taking or have you ever taken AREDIA or ZOMETA? ________ Yes No
7. List any medications or drugs you are taking: ______________________

   ______________________________________________

8. List any medications or drugs you cannot take or are allergic to: ______________________

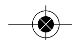
   ______________________________________________

9. Have you ever had any of the following: (Please check the appropriate answers)

| | Yes | No | | | Yes | No | | | Yes | No | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| a. | ____ | ____ | Rheumatic/Scarlet Fever | m. | ____ | ____ | Asthma | w. | ____ | ____ | Hemophilia |
| b. | ____ | ____ | Heart disease/Angina | n. | ____ | ____ | Arthritis | x. | ____ | ____ | Anemia/Leukemia |
| c. | ____ | ____ | Heart murmur | o. | ____ | ____ | Hepatitis/Jaundice | y. | ____ | ____ | HIV or Aids |
| d. | ____ | ____ | Heart surgery | p. | ____ | ____ | Liver Disease | z. | ____ | ____ | Cancer |
| e. | ____ | ____ | Pacemaker | q. | ____ | ____ | Tuberculosis | aa. | ____ | ____ | Radiation/chemotherapy |
| f. | ____ | ____ | Artificial heart valves | r. | ____ | ____ | Seizures or epilepsy | bb. | ____ | ____ | Steroid treatment |
| g. | ____ | ____ | Mitral valve prolapse | s. | ____ | ____ | Kidney disease/Transplant | cc. | ____ | ____ | Do you smoke, use chewing tobacco or snuff? |
| h. | ____ | ____ | Congenital heart lesions | t. | ____ | ____ | Diabetes | | | | |
| i. | ____ | ____ | Stroke | u. | ____ | ____ | Abnormal bleeding | dd. | ____ | ____ | Alcohol usage |
| j. | ____ | ____ | Joint replacements | v. | ____ | ____ | Thyroid disease | ee. | ____ | ____ | Drug/Alcohol abuse |
| k. | ____ | ____ | Dialysis shunt | w. | ____ | ____ | Latex Allergy | ff. | ____ | ____ | Birth control pills/ Fertility drugs |
| l. | ____ | ____ | High blood pressure | x. | ____ | ____ | Metal Allergy | | | | |

**over please**

**200 East Mantua Avenue, Wenonah, NJ 08090**
**(856) 468-5858**



10. Chief dental complaint ______________________________

| | | | |
|---|---|---|---|
| Have you ever had treatment for your gums? | Yes | No | When/by whom? ______________ |
| Have you ever had orthodontics (braces)? | Yes | No | When/by whom? ______________ |
| Do you have dental implants? | Yes | No | |
| Do you grind your teeth? | Yes | No | |
| Have you ever been told you snore? | Yes | No | |

How do you feel about the appearance of your teeth? ______________________________

Is there anything we can do to make you more comfortable during your visit here? ______________________________

Please list any diseases, conditions, or problems not included in the above medical history: ______________________________

Additional Comments for any items marked "yes". (Include item number and explanation.)

I certify that I have reviewed the above information concerning my health and it is true, accurate and complete to the best of my knowledge. I understand that this information will be relied upon in rendering treatment to me. If I ever have any change in my health, or if my medicines change, I will inform the doctor at the next appointment without fail.

SERVICE CHARGE of 1½% per month or 18% per year will be added to and thereafter accrue upon unpaid balances of all invoices that are 30 days past due.

| ______________________________ | ______________________________ |
|---|---|
| Reviewed by | Patient Signature |
| Thank you. | Date: ______________________________ |

DOCTOR'S SECTION:

B.P. ______________ Pulse ______________

UPDATES: