WENTWORTH
FAMILY DENTAL

Name:		Today's date:
Address:		Postal Code:
Phone HM:	Work:	Cell:
Date of Birth:	Sex: M F	Email Address:
Employer:		Occupation:
Emergency Contact:		Phone:

Physician:_____ Phone: _____Previous Dentist:_____ Phone #_____

Who can we thank for referring you to our clinic?_____

MEDICAL HISTORY

When did you last see your physician, and for what reason? _____

Do you have any drug allergies that you are aware of? Yes No Please list:_____

Do you have a Latex Allergy? Yes No

Have you ever been hospitalized? Yes No If Yes, for what reason?_____

Did a dentist, physician or specialist ever recommend taking antibiotics prior to dental treatment or surgery? YES NO

Are you taking any Medications or Supplements? Yes No If 'yes' please List:_____

_____

Please Circle any of the following conditions that apply to you, past or present.

Anemia	*Diabetes*	*HIV/AIDS*	*Rheumatic Fever*
Arthritis	*Drug Use*	*High Blood Pressure*	*Sinus problems*
Artificial Joints	*Epilepsy*	*Jaundice*	*Sleep Apnea*
Asthma	*Fainting*	*Kidney disease*	*Snoring*
Blood Disorders	*Gastrointestinal*	*Liver problems*	*Stroke*
Breathing Problems	*Growth or tumor*	*Low Blood Pressure*	*Surgery*
Cancer	*Heart Attack*	*Mental/Nervous disorders*	*Thyroid problems*
Clotting/Bleeding Problems	*Heart Disease*	*Migraines/headaches*	*Tuberculosis*
Cold Sores	*Heart Murmur*	*Osteoporosis*	*Ulcers*
Depression	*Hepatitis A - B - C*	*Pacemaker*	

Is there anything else you would like us to know about your health?_____

WOMEN:
Are you pregnant? YES NO Birth control pills or HRT? YES NO Are you in peri-menopause or menopause? YES NO

Appointment Policy:

*We would like to ask for your help in providing a minimum of **TWO BUSINESS DAYS NOTICE** if for any reason you will be unable to keep a scheduled appointment.*
This consideration will allow us to accommodate those patients that may be waiting for an appointment.
If you are unable to provide notice, there will be a $60.00 short notice cancellation fee.
For your convenience, we will continue to call or email you prior to your appointment to remind you of your visit.

I_____ have read & understand the above policy. Date:_____ Signature:_____

DENTAL HISTORY

Purpose of Visit today? _____

Have you ever experience any of the following?

Does your jaw click or hurt?	❍Yes	Do you smoke?	❍Yes
Do you think you grind your teeth?	❍Yes	Do you ever have bad breath?	❍Yes
Have you ever had orthodontic treatment?	❍Yes	Do your gums bleed when you brush?	❍Yes
Do you wear a night guard?	❍Yes	Do you experience hot/cold sensitivity?	❍Yes
Have you ever had gum disease?	❍Yes	Does floss ever tear between your teeth?	❍Yes
Have you ever had your bite adjusted?	❍Yes	Does food get stuck between your teeth?	❍Yes
Do you bite your cheeks or lips often?	❍Yes	Do your teeth hurt when you bite hard?	❍Yes
Does your mouth often seem dry?	❍Yes	Have you been told you have deep pockets	❍Yes

Are any of your teeth sensitive or aching? YES NO Which tooth/area?_____

When was your last visit to a dental office?_____Last professional cleaning?_____ Last xrays?_____

What is your dental comfort level on a scale from **1** to **10**? *(not comfortable)* 1 2 3 4 5 6 7 8 9 10 *(completely comfortable)*

How often do you brush your teeth? Floss? Do you use: Mouthwash, Toothpicks, Proxy-brush, Floss threaders

Any other condition related to the health of your gums? YES NO (Please List)_____

The following list of symptoms can be a sign of TMJ/TMD or bite problems. Please circle any that may apply to you

Back/Neck pain	Ear congestion	Insomnia	Tender/sensitive teeth
Bell's Palsy	Facial Pain	Joint popping/clicking	Tingling in fingertips
Clenching	Grinding	Limited opening	TMJoint pain
Difficulty chewing	Headaches	Loose teeth	Trigeminal Neuralgia
Difficulty swallowing	Hot/Cold sensitivity	Ringing in the ears (Tinnitis)	

Rate your SMILE from **1** to **10**? 1 2 3 4 5 6 7 8 9 10 *(Love my smile)*

What would you like to change or improve in your teeth?_____

Is there anything you would like to make us aware of that has not been covered on this form? YES NO

PERMISSION TO TREAT, RELEASE OF INFORMATION & PRIVACY.

I hearby authorize the doctor or designated team to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand I can ask for a complete recital of any possible complications. I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependents that isn't covered by insurance.

Patients/Guardian Signature:_____ Date:_____

DENTAL INSURANCE

We are more than happy to bill your insurance company directly. We do require a credit card on file so we can process the difference as soon as we receive payment. Whenever possible, we will electronically send your insurance claims and find out the difference immediately.

Primary

Employer:_____ Provider:_____ Group #:_____ I.D #_____

Secondary

Employer:_____ Provider:_____ Group #:_____ I.D #_____

(If the insurance belongs to your spouse please add Name:_____ Birthday_____)