

WELCOME TO WELLS FAMILY DENTISTRY

*Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs, please fill out this form
completely in ink. If you have any questions or need assistance, please ask us –
we will be happy to help.*

Patient Information (CONFIDENTIAL)

Patient # _____
SS#/SIN _____
Date _____
Home Phone _____
Address _____ City _____ State _____ Zip _____
Email _____ Cell Phone _____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
If Student, Name of School/College _____ City _____ State _____ ☐ Full Time ☐ Part Time
Patient or Parent/Guardian's Employer _____ Work Phone _____
Business Address _____ City _____ State _____ Zip _____
Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____
Whom may we thank for referring you? _____
Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____ Home Phone _____
Email _____ Cell Phone _____
Driver's License # _____ Birthdate _____ Financial Institution _____
Employer _____ Work Phone _____ SS#/SIN _____
Is this person currently a patient in our office? ☐ Yes ☐ No
For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.
☐ Cash ☐ Personal Check ☐ Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local# _____ Work Phone _____
Address of Employer _____ City _____ State _____ Zip _____
Insurance Company _____ Group# _____ Policy/ID# _____
Ins. Co. Address _____ City _____ State _____ Zip _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:
Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local# _____ Work Phone _____
Address of Employer _____ City _____ State _____ Zip _____
Insurance Company _____ Group# _____ Policy/ID# _____
Ins. Co. Address _____ City _____ State _____ Zip _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

Over Please

Patient Medical History

Physician _____	Office Phone _____	Date of Last Exam _____	
1. Are you under medical treatment now?	Yes <input type="checkbox"/> No <input type="checkbox"/>	10. Are you wearing contact lenses?	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	Yes <input type="checkbox"/> No <input type="checkbox"/>	11. Are you allergic to or have you had any reactions to the following?	
If yes, please explain		Local Anesthetics (e.g. Novocain)	Yes <input type="checkbox"/> No <input type="checkbox"/>
		Penicillin or any other Antibiotics	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Are you taking any medication (s) including non-prescription medicine?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sulfa Drugs	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, what medication(s) are you taking?		Barbiturates	Yes <input type="checkbox"/> No <input type="checkbox"/>
		Sedatives	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Have you ever taken Fen-Phen/Redux?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Iodine	Yes <input type="checkbox"/> No <input type="checkbox"/>
5. Have you ever taken Fosamx, Boniva, Actonel or any cancer medications containing bisphosphonates?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Aspirin	Yes <input type="checkbox"/> No <input type="checkbox"/>
6. Have you taken Viagra, Revati, Cialis or Levitra in the last 24 hours?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Any Metals (e.g. nickel, mercury, etc.)	Yes <input type="checkbox"/> No <input type="checkbox"/>
7. Do you use tobacco?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Latex Rubber	Yes <input type="checkbox"/> No <input type="checkbox"/>
8. Do you use controlled substances?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Other (please list)	
9. Do you have or have you had any of the following?		12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Yes <input type="checkbox"/> No <input type="checkbox"/>	13. Women Only:	
High Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>	a) Are you pregnant or think you may be pregnant?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Heart Attack	Yes <input type="checkbox"/> No <input type="checkbox"/>	b) Are you nursing?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Rheumatic Fever	Yes <input type="checkbox"/> No <input type="checkbox"/>	c) Are you taking oral contraceptives?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Swollen Ankles	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Fainting / Seizures	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Asthma	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Low Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Epilepsy / Convulsions	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Leukemia	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Kidney Diseases	Yes <input type="checkbox"/> No <input type="checkbox"/>		
AIDS or HIV Infection	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Thyroid Problem	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Heart Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Cardiac Pacemaker	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Heart Murmur	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Angina	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Frequently Tired	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Anemia	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Emphysema	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Arthritis	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Joint Replacement or Implant	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Hepatitis / Jaundice	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Sexually Transmitted Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Stomach Troubles / Ulcers	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Chest Pains	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Easily Winded	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Stroke	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Hay Fever / Allergies	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Tuberculosis	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Radiation Therapy	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Glaucoma	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Recent Weight Loss	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Liver Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Heart Trouble	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Respiratory Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Mitral Valve Prolapse	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Other	Yes <input type="checkbox"/> No <input type="checkbox"/>		

Patient Dental History

Name of Previous Dentist and Location _____	Date of Last Exam _____
1. Do your gums bleed while brushing or flossing?	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Are your teeth sensitive to hot or cold liquids / foods?	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Are your teeth sensitive to sweet or sour liquids / foods?	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Do you feel pain to any of your teeth?	Yes <input type="checkbox"/> No <input type="checkbox"/>
5. Do you have any sores or lumps in or near your mouth?	Yes <input type="checkbox"/> No <input type="checkbox"/>
6. Have you had any head, neck or jaw injuries?	Yes <input type="checkbox"/> No <input type="checkbox"/>
7. Have you ever experienced any of the following problems in your jaw?	
Clicking	Yes <input type="checkbox"/> No <input type="checkbox"/>
Pain (joint, ear, side of face)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Difficulty in opening or closing	Yes <input type="checkbox"/> No <input type="checkbox"/>
Difficulty in chewing	Yes <input type="checkbox"/> No <input type="checkbox"/>
8. Do you have frequent headaches?	Yes <input type="checkbox"/> No <input type="checkbox"/>
9. Do you clench or grind your teeth?	Yes <input type="checkbox"/> No <input type="checkbox"/>
10. Do you bite your lips or cheeks frequently?	Yes <input type="checkbox"/> No <input type="checkbox"/>
11. Have you ever had any difficult extractions in the past?	Yes <input type="checkbox"/> No <input type="checkbox"/>
12. Have you ever had any prolonged bleeding following extractions?	Yes <input type="checkbox"/> No <input type="checkbox"/>
13. Have you had any orthodontic treatment?	Yes <input type="checkbox"/> No <input type="checkbox"/>
14. Do you wear dentures or partials?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, date of placement	
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	Yes <input type="checkbox"/> No <input type="checkbox"/>
16. Do you like your smile?	Yes <input type="checkbox"/> No <input type="checkbox"/>

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental Care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

Signature of patient (or parent / guardian if minor) _____

Date _____

Doctor's Comments _____

Signature _____

Date _____