Jane Walker, DDS
27 Water Street
Milford, Ohio 45150
**Confidential Patient Information**

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| Patient’s Legal Name Last, First MI | Date of Birth | Sex | Social Security Number |
| Prefer to be called: | Home Phone # | Cell Phone # |
| Patient’s Address Street Apt.# City State/Zip | E-MAIL |
| Marital Status:S M W D Under Age 18 | Patient’s Employer: | Occupation: |
| Work Address Street Apt.# City State/Zip | Work Phone # |
| Other Family Members That Are Patients Here: |
| How did you hear about our Office?□ I have been a patient of Dr. Guju□ I have been a patient of Dr. Walker□ Website□ Drive by□ Referral, who may we thank: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |
| **PERSON WE MAY CONTACT IN CASE OF AN EMERGENCY**  |
| Name: | Relationship: |
| Home Phone # | Work Phone # | Cell Phone # |
|  |
| **As My Dental Care Provider, You may do the following with My Permission: YES NO**  |
| Contact me at home |  □ □ |
| Contact/text me via cell phone |  □ □ |
| Contact me at work |  □ □ |
| Contact me via e-mail at address above |  □ □ |
| Leave message on my home voicemail/answering machine |  □ □ |
| Leave messages on my cell phone voicemail |  □ □ |
| Leave messages on my work voicemail/answering machine |  □ □ |
| **PRIMARY INSURANCE COVERAGE** YES NO | Insurance Company Name | Insurance Address | Insurance Phone |
| Subscriber’s Name | Patient’s Relationship to Subscriber Self Spouse DependentSubscriber ID/Member # | Subscriber’s Birthday | Social Security # |
| Group/Program Number | Subscriber’s Employer | Employer’s Address |
| **SECONDARY COVERAGE** YES NO | Insurance Company Name | Insurance Address | Insurance Phone |
| Subscriber’s Name | Patient’s Relationship to Subscriber Self Spouse DependentSubscriber ID/Member # | Subscriber’s Birthday | Social Security # |
| Group/Program Number | Subscriber’s Employer | Employer’s Address |

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| **YOU MAY DISCUSS MY HEALTHCARE WITH** |
|  **YES NO** | **OTHERS** (please print) |
| Health Care Providers □ □ | 1. |
| Insurance Companies □ □ | 2.  |

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| **Authorization & Release** |
| I hereby authorize (1) any available insurance benefits to be paid directly to my dentist, (2) the release of my dental health care information for any of my dental care insurance claim, (3) the use of my dental records by my dentist in any professional manner that he/she determines and (4) the making of videotapes, photographs, and x-rays of my dental care treatment (collectively “My Images. I agree that to the extent the cost of the dental care provided by my dentist is not covered by insurance, I am obligated to pay him/her such uninsured cost (the “Uninsured Costs”) in accordance with his/her payment terms and policies. Finally, I certify that I have read or had read to me the contents of this form and understand the risks and limitations involved with the dental treatment that I am to receive. |
| SIGNATURE – Patient / Guardian | DATE |
|  |  |
| If the above named Patient is a minor or unable to pay the his/her Uninsured Costs, the undersigned agrees to guaranty the payment of such Uninsured Costs to the Patient’s dentist in accordance with his/her payment terms and policies. |
| SIGNATURE – Guarantor of Patient | DATE |

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| **MEDICAL HISTORY** |
| Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nickname\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Primary care doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Office phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| **1. Are you currently under medical treatment? □Yes □No** |  |  |  |  |  |
| **2. Have you been hospitalized for any reason in the last five years? □Yes □No** |  |  |  |  |
| If **Yes** to question 1 or 2 please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| 3. **Are you allergic to or have you had a bad reaction to:** |  |  |  |  |  |
|  | **Yes No** |  |  |  | **Yes No** |  |  | **Yes No** |
| Aspirin |  □ □ |  | Penicillin |  |  □ □ |  | Local anesthetic (Novocain) |  □ □ |
| Ibuprofen |  □ □ |  | Erythromycin |  |  □ □ |  | Fluoride |  □ □ |
| Acetaminophen |  □ □ |  | Tetracycline |  |  □ □ |  | Metals (e.g. nickel, gold, silver) |  □ □ |
| Codeine |  □ □ |  | Sulfa |  |  □ □ |  | Latex |  □ □ |
|  |  |  |  |  |  |  | Other; list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 4. **Do you have or have you had any of the following:** |  |  |  |  |  |
|  | **Yes No** |  |  |  | **Yes No** |  |  | **Yes No** |
| Heart surgery |  □ □ |  | Chicken Pox |  |  □ □ |  | Epilepsy, convulsions (seizures) |  □ □ |
| Heart attack |  □ □ |  | Shingles |  |  □ □ |  | ADD/ADHD |  □ □ |
| Other heart issues |  □ □ |  | Sleep apnea |  |  □ □ |  | Asthma |  □ □ |
| Pacemaker |  □ □ |  | Kidney disease |  |  □ □ |  | Viral infections & cold sores |  □ □ |
| Joint replacement/implant |  □ □ |  | Liver disease |  |  □ □ |  | Lumps or swelling in the mouth |  □ □ |
| Rheumatic or scarlet fever |  □ □ |  | Thyroid disease |  |  □ □ |  | Hives, skin rash, hay fever |  □ □ |
| High blood pressure |  □ □ |  | High cholesterol |  |  □ □ |  | STI/STD/HPV |  □ □ |
| Stroke |  □ □ |  | Stomach or duodenal ulcer |  □ □ |  | Hepatitis (type\_\_\_\_\_\_\_\_) |  □ □ |
| Anemia or other blood disorder |  □ □ |  | Digestive disorders  |  |  □ □ |  | HIV/AIDS |  □ □ |
| Prolonged bleeding  |  □ □ |  | Osteoporosis/osteopenia |  □ □ |  | Tumor, abnormal growth |  □ □ |
| Emphysema/COPD |  □ □ |  | Autoimmune disease  |  □ □ |  | Radiation therapy |  □ □ |
| Shortness of breath |  □ □ |  | Arthritis |  |  □ □ |  | Chemotherapy |  □ □ |
| Tuberculosis |  □ □ |  | Head or neck injuries |  □ □ |  | Alcohol abuse |  □ □ |
| Other lung disease |  □ □ |  | Migraines or frequent headaches |  □ □ |  | Drug abuse |  □ □ |
| Measles |  □ □ |  |  |  |  |  |  |  |
| Other, list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| **5. Are you taking prescriptions or over the counter drugs (including any vitamins or supplements) ? □Yes □No** |  |
| **If yes, please list all: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| **6. Do you use tobacco in any form? □Yes □No** |  |  |  |  |  |
| **7. Do you take a daily aspirin or blood thinner? □Yes □No** |  |  |  |  |  |
| **8. Do you take a bisphosphonate (e.g. Fosamax, Boniva, Actonel)? □Yes □No** |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| **WOMEN ONLY:** |  |  |  |  |  |  |  |  |
| **9. Are you or could you be pregnant? □Yes □No** |  |  |  |  |  |
| **10. Are you taking birth control medication? □Yes □No** |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| **ALL:** |  |  |  |  |  |  |  |  |
| **Please advise us in the future of any changes in your medical history or medications listing** |
| Patient's Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_ |  |
| Doctor's Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_ |  |

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| **DENTAL HISTORY** |
| Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nickname\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Referred by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How would you rate the condition of your mouth? □Excellent □Good □Fair □Poor |
| I routinely see my dentist every: □ 3 mo. □ 4 mo. □ 6 mo. □ 12 mo. □ Not routinely |
| **WHAT IS YOUR IMMEDIATE CONCERN?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ***PLEASE ANSWER YES OR NO TO THE FOLLOWING:* YES NO** |
| **PERSONAL HISTORY** |
| 1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [\_\_\_\_]  |  □ □ |
| 2. Have you had an unfavorable dental experience?  |  □ □ |
| 3. Have you ever had complications from past dental treatment?  |  □ □ |
| 4. Have you ever had trouble getting numb or had any reactions to local anesthetic?  |  □ □ |
| 5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?  |  □ □ |
| 6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma? |  □ □ |
| **GUM AND BONE** |
| 7. Do your gums bleed or are they painful when brushing or flossing?  |  □ □ |
| 8. Have you ever been treated for gum disease or been told you have lost bone around your teeth?  |  □ □ |
| 9. Have you ever noticed an unpleasant taste or odor in your mouth?  |  □ □ |
| 10. Is there anyone with a history of periodontal disease in your family? |  □ □ |
| 11. Have you ever experienced gum recession? |  □ □ |
| 12. Have you ever had teeth become loose on their own (without an injury), or do you have difficulty eating an apple? |  □ □ |
| 13. Have you experienced burning or painful sensation in your mouth not related to your teeth?  |  □ □ |
| **TOOTH STRUCTURE** |
| 14. Have you had any cavities within the past 3 years? |  □ □ |
| 15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?  |  □ □ |
| 16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?  |  □ □ |
| 17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?  |  □ □ |
| 18. Do you have grooves or notches on your teeth near the gum line? |  □ □ |
| 19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?  |  □ □ |
| 20. Do you frequently get food caught between any teeth?  |  □ □ |
| **BITE AND JAW JOINT** |
| 21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)  |  □ □ |
| 22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together?  |  □ □ |
| 23. Do you have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?  |  □ □ |
| 24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?  |  □ □ |
| 25. Are your teeth becoming more crooked, crowded, or overlapped?  |  □ □ |
| 26. Are your teeth developing spaces or becoming loose?  |  □ □ |
| 27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your  teeth fit together?  |  □ □ |
| 28. Do you place your tongue between your teeth or close your teeth against your tongue?  |  □ □ |
| 29. Do you chew ice, bite your nails, use teeth to hold objects, or have any oral habits?  |  □ □ |
| 30. Do you clench or grind your teeth together in the daytime or make them sore?  |  □ □ |
| 31. Do you have any problems with sleep (i.e. teeth grinding)? |  □ □ |
| 32. Do you wear or have you ever worn a bite appliance?  |  □ □ |
| **SMILE CHARACTERISTICS** |
| 33. Is there anything about the appearance of your teeth that you would like to change (shape, color, size)? Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  □ □ |
| 34. Have you ever whitened (bleached) your teeth? |  □ □ |
| 35. Have you felt uncomfortable or self-conscious about the appearance of your teeth?  |  □ □ |
| 36. Have you been disappointed with the appearance of previous dental work?  |  □ □ |
| Patient’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Doctor’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |