West Annapolis Family Dentistry

101 RIDGELY AVENUE • ANNAPOLIS, MARYLAND 21401-1491
TELEPHONE 410-263-3700 • BALTIMORE 410- 269-1009 • WASHINGTON 410-858-6313

PATIENT INFORMATION AND HEALTH HISTORY

PATIENT NAME _____ _____ _____ AGE _____ DATE OF BIRTH _____
FIRST MIDDLE LAST

PATIENT ADDRESS _____ _____ HOME PHONE _____
STREET

_____ _____ _____
CITY STATE ZIP CODE

CELL PHONE/BEEPER _____

EMPLOYED BY _____ OCCUPATION _____

ADDRESS OF EMPLOYER _____ BUSINESS PHONE _____

PATIENT SOCIAL SECURITY NO. _____ REFERRED BY _____

PATIENT DRIVERS LICENSE/SOUNDEX NUMBER _____

SPOUSE'S NAME _____ SPOUSE'S SOCIAL SECURITY NO. _____

SPOUSE'S EMPLOYER _____ ADDRESS _____ PHONE _____

DENTAL INSURANCE PLAN (If Any) _____ DENTAL PLAN NO. _____

SPOUSE'S DENTAL INSURANCE PLAN _____ SPOUSE'S DENTAL PLAN NO. _____

PERSON RESPONSIBLE FOR THIS ACCOUNT _____ PHONE _____

☐ CHECK IF SAME AS ABOVE _____ _____ _____
HOME ADDRESS BUSINESS ADDRESS BUSINESS PHONE

LIST ALL DEPENDENTS SEEN IN THIS OFFICE _____

MEDICAL HISTORY

NAME OF PHYSICIAN & TELEPHONE _____ DATE OF LAST EXAM _____

1. Are you in good health? YES NO
2. Has there been any change in your general health within the last year? YES NO
3. Have you had any serious illness, operation or been hospitalized in the past 5 years? YES NO

   If so, what was the illness? _____

   _____
4. Are you taking any medicines? YES NO

   If so, list any medications you are presently taking _____

   _____

   _____
5. Have you ever used Phen-fen or Redux? YES NO

Please check Yes or No if you received medical treatment or if you have had any of the following conditions:

1. Artificial heart valves or heart surgery ..... YES NO
2. Heart murmur or rheumatic heart disease or mitral valve prolapse ..... YES NO
3. Heart attack, heart trouble, angina, chest pain upon exertion ..... YES NO
4. High Blood Pressure ..... YES NO
5. Cardiac pacemaker ..... YES NO
6. Hepatitis, yellow jaundice or liver disease ..... YES NO
7. Diabetes ..... YES NO
8. Kidney Trouble ..... YES NO
9. Epilepsy or Seizures ..... YES NO

-Over-

10. Fainting spells or dizziness ..... YES NO
11. Aids or HIV Infection ..... YES NO
12. Thyroid problems or hormone imbalance ..... YES NO
13. Sexually transmitted disease or venereal disease ..... YES NO
14. Stomach ulcer or surgery ..... YES NO
15. Mental health problems or depression ..... YES NO
16. Cancer, Radiation Therapy & Chemotherapy ..... YES NO
17. Stroke or paralysis ..... YES NO
18. Lupus ..... YES NO
19. Steroid Medications ..... YES NO
20. Alcoholism or drug dependency ..... YES NO
21. Emphysema ..... YES NO
22. Tuberculosis ..... YES NO
23. Asthma or hay fever ..... YES NO
24. Sinus problems ..... YES NO
25. Anemia ..... YES NO
26. Bruise or bleed easily or hemophilia ..... YES NO
27. Blood transfusions ..... YES NO
28. Arthritis ..... YES NO
29. Prosthetic joints ..... YES NO
30. Headaches or migraines ..... YES NO
31. Organ transplants or immunosuppressive drugs ..... YES NO
32. Are you allergic to or had a reaction to:
    a) Local anesthetics (novocaine) ..... YES NO
    b) Penicillin or other antibiotics ..... YES NO
    c) Aspirin ..... YES NO
    d) Codeine ..... YES NO
    e) Latex - Rubber ..... YES NO
33. Do you have any disease, condition or problem not listed above that we should know about?_____

_____

WOMEN:

Are you pregnant? YES NO

Are you nursing? YES NO

Are you taking birth control pills? YES NO

DENTAL HISTORY

Date of last dental exam _____ Have you had full mouth x-rays taken (when) _____

Indicate with a ✓ if you have or had any of the following:

- ☐ Teeth sensitive to hot, cold sweets or pressure
- ☐ Bleeding gums
- ☐ Lumps or blisters on lips or mouth
- ☐ Jaws pop or click when opening
- ☐ Cigarette, pipe or cigar smoker
  How much?_____
- ☐ Grinding or clenching teeth
- ☐ Oral surgery
- ☐ Periodontal (gum) surgery
- ☐ Orthodontic treatment (braces. Year competed _____
- ☐ Type of toothbrush (soft-medium-hard) _____
  Do you floss? _____ How often? _____
- ☐ Do you wear removable dental appliances?
- ☐ Do you wear a mouthguard?

Have you had any serious trouble with any previous dental treatment? _____

PLEASE NOTE: To avoid misunderstanding regarding dental insurance, we wish our patients to know that insurance does not cover all fees charged. Payment of fees not covered are the responsibility of the patient.

Signature _____ Date _____