PATIENT INFORMATION

First Name _____ MI ____ Last Name _____ Preferred Name _____

Patient Date Of Birth _____ Salutation _____ Gender _____ Marital Status _____

Physical Address _____ City _____ State _____ Zip Code _____

Mailing Address (if different from above) _____ City _____ State _____ Zip Code _____

Patient Social Security # _____ Patient Phone # _____ Email Address _____

Preferred contact method

☐ Phone Call ☐ Text Message ☐ Email

May we leave a Voicemail or send a Text to this #

☐ Voicemail only ☐ Text Only ☐ Text and Voicemail

Patients Preferred Pharmacy _____ Pharmacy Phone # _____

Have you been diagnosed with any medical condition that may affect your memory or your ability to retain and remember health information and treatment discussed during your appointments? (If yes please list condition and Dr's name)

☐ Yes _____ ☐ No

Are you currently taking any medications that may alter your judgement, or make you unable to make decisions regarding your care? (If yes please list medication) ☐ Yes _____ ☐ No

RESPONSIBLE PARTY INFORMATION

Responsible Party's Name (if not the patient) _____ Responsible Party's Relationship to Patient _____

Responsible Party's Address _____ City _____ State _____ Zip Code _____

Responsible Party's Phone # _____

Responsible Parties Preferred Contact Method

☐ Phone Call ☐ Text ☐ Email _____

Emergency Contact First and Last Name _____ **Phone Number** _____

(May we contact this person regarding your account and medical information, if necessary)

☐ **Account Only** ☐ **Medical Information only** ☐ **Any Necessary information**

INSURANCE INFORMATION

Employer's Name _____ Occupation _____ Work Phone Number _____

Primary Insurance Company Name _____ Group # _____ Policy ID # _____

Primary Insurance Address _____ City _____ State _____ Zip Code _____

Policy Holder's First and Last Name _____ Policy Holder's Date of Birth ____/____/____

Policy Holder's Social Security # _____ Policy Holder's Phone Number _____

Secondary Insurance Company Name _____ Group# _____ Policy ID # _____

Secondary Insurance Address _____ City _____ State _____ Zip Cide _____

Policy Holder's First and Last Name _____ Policy Holder's Date of Birth ____/____/____

Policy Holder's Social Security # _____ Policy Holder's Phone Number _____

Medicaid ID # _____ **First and Last Name (as it appears on card)** _____

GUARANTOR (PERSON RESPONSIBLE FOR PAYMENT)

☐ Self ☐ Responsible Party ☐ Other

If you selected other, please fill out the section below:

Name (First and Last) _____ Date of Birth ____/____/____ Social Security # _____

Phone Number _____ Address _____ City _____ State _____ Zip Code _____

2023 Wells Dentistry Medical History

Patient Name: Birth Date: Date Created:

History

Who was your previous dentist? How long ago were you seen, and what were you seen for?		Comment	
How did you hear about us?		Comment	

* Has a doctor prescribed you a Pre-Medication to take prior to dental appointments?	◯ Yes ◯ No	If yes	
Are you under a physician's care now?	◯ Yes ◯ No	If yes	
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes	
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes	
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes	
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes	
Are you on a special diet?	◯ Yes ◯ No		
Do you use or have you ever used tobacco? If yes, what type and how often?	◯ Yes ◯ No	If yes	
Do you use controlled substances, or recreational drugs? If yes, what type and how often?	◯ Yes ◯ No	If yes	
Do you drink alcohol? If yes, how often?	◯ Yes ◯ No	If yes	
Have you taken any steroids in the last 2 years? eg. cortisone	◯ Yes ◯ No	If yes	
Have you had a major change in health in the last 12 months? If yes, what?	◯ Yes ◯ No	If yes	

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No	Alzheimer's Disease ◯ Yes ◯ No
Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No	Anaphylaxis ◯ Yes ◯ No
Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No	Anemia ◯ Yes ◯ No
Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No
High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No	Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No
High Cholesterol ◯ Yes ◯ No	Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No
Shingles ◯ Yes ◯ No	Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No
Sickle Cell Disease ◯ Yes ◯ No	Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No
Sinus Trouble ◯ Yes ◯ No	Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No
Spina Bifida ◯ Yes ◯ No	Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problems ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No	Cancer ◯ Yes ◯ No
Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No	Chemotherapy ◯ Yes ◯ No
Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No	Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No
Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No	Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No
Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No	Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No
Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No	Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No
Psychiatric Care ◯ Yes ◯ No	Depression ◯ Yes ◯ No	Eating Disorder ◯ Yes ◯ No	Snoring ◯ Yes ◯ No
Dry Mouth ◯ Yes ◯ No	Clench _Grind Teeth ◯ Yes ◯ No	Bleeding Disorder ◯ Yes ◯ No	Acid Reflux/ Heartburn ◯ Yes ◯ No
Daytime Sleepiness ◯ Yes ◯ No	Organ Transplant ◯ Yes ◯ No	Infective Endocarditis ◯ Yes ◯ No	Sleep Apnea ◯ Yes ◯ No
Adrenal Gland Disorder ◯ Yes ◯ No	STD ◯ Yes ◯ No	Ear Ache ◯ Yes ◯ No	Bleeding Gums ◯ Yes ◯ No
Pain in Face muscles ◯ Yes ◯ No	Ear Ringing ◯ Yes ◯ No		

Have you ever had any serious illness not listed above?	◯ Yes ◯ No	If yes	
If yes to any of the above please elaborate further.		Comment	

Women: Are you...

- [ ] Pregnant
- [ ] Nursing
- [ ] Taking oral contraceptives
- [ ] Trying to get Pregnant

Are you allergic to any of the following?

- [ ] Aspirin
- [ ] Penicillin
- [ ] Codeine
- [ ] Acrylic
- [ ] Metal
- [ ] Latex
- [ ] Sulfa Drugs
- [ ] Local Anesthetics
- [ ] Antibiotics
- [ ] Narcotics
- [ ] Food(s)

Other? ☐ If yes _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____

Name: Birthdate: Date of latest update:

Medication List

Medication	**Frequency**

Please include both prescription and over the counter medications and supplements to help us give you the best care possible. Thank you for being thorough and honest with this list.

Wells Dentistry Signatures

HIPPA Notice of Privacy Practices

I hereby acknowledge that I have received and reviewed a copy of Dr. Wells Office HIPPA Notice of Privacy Practices. I understand that Dr. Wells Office HIPPA Notice of Privacy Practices may change periodically and that I am entitled to receive a copy of Dr. Wells Office HIPPA Notice of Privacy Practices upon request.

Patient Signature _____ **Date** _____

Informed Consent Acknowledgement

I hereby acknowledge that I have received and reviewed a copy of Dr. Wells Office Informed Consent Agreement. This includes but is not limited to; Health Information; Drugs and Medications; Changes in Treatment Plan; Local Anesthetic; Removal of Teeth; Implants; Crowns and Bridges; Endodontic Treatment (root canal); Periodontal loss (tissue and bone); X-Ray and Examination; Fillings; and Dentures. I understand that Dr. Wells Office Informed Consent Agreement may change periodically and that I am entitled to receive a copy of Dr. Wells Informed Consent upon request.

Patient Signature _____ **Date** _____

Nitrous Oxide Consent

I hereby acknowledge that I have received and reviewed a copy of Dr. Wells Office Nitrous Oxide Consent

Patient Signature _____ **Date** _____

Financial Policy Consent

I hereby acknowledge that I have received and reviewed a copy of Dr. Wells Office Financial Policy. By signing this statement, you agree to be financially responsible for all charges.

Patient Signature _____ **Date** _____

Late and Missed Appointment Policy

I hereby acknowledge that I have received and reviewed a copy of Dr. Wells Office Late and Missed Appointment Policy. By signing this statement, you agree to follow the terms of this policy completely and be on time and present to all scheduled appointments, unless a 48-hour cancellation has been given.

Patient Signature _____ **Date** _____