Welcome to West Memphis Dental Group!

GENERAL INFORMATION:

Name: ______________________ Today's Date: ____________
Birthdate: ____________ Age: ______ Social Security #: ____________
Address: ______________________ Email Address: ____________
City: ____________ State: ____________ Zip Code: ____________
How long have you lived there? ________ Home Phone: ____________
Cell Phone: ______________ Work Phone: ______________
Employer: ______________ How long have you worked there? ________
Employer Address: ______________________________

Status: ❑ Single ❑ Divorced ❑ Minor
❑ Married ❑ Separated ❑ Widowed

Spouse's Name: ______________

Do you have children? ❑ Yes ❑ No If so, how many? ____________

REFERRAL INFORMATION:

How did you hear about us?

❑ From another patient: ____________
❑ From a staff member: ____________
❑ Other: ______________
❑ Facebook or website
❑ From an advertisement ____________

DENTAL HISTORY

Previous Dentist: ______________ Date of last dental exam: ________
Have you had dental X-rays in the last year? ❑ Yes ❑ No
Are you nervous about dental treatment? ❑ Yes ❑ No
How many times a day do you brush? ________ Floss? ________
What type of toothbrush bristles do you use? ❑ Soft ❑ Medium ❑ Hard
How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best)

TODAY'S VISIT

Reason for today's visit: ❑ Exam ❑ Emergency ❑ Consultation
Are you in pain? ❑ Yes ❑ No If yes, for how long? ____________

Please check the box if you currently have any of the following conditions:

❑ Discomfort, clicking, or popping of jaws
❑ Blisters/sores in or around mouth
❑ Red, swollen, or bleeding gums
❑ Sensitive tooth, teeth, or gums
❑ Lost/broken filling(s)
❑ Bad breath
❑ Ringing in ears
❑ Broken/chipped tooth
❑ Locking jaw
❑ Teeth grinding
❑ Stained teeth
❑ Other: ________

EMERGENCY CONTACT INFORMATION:

Name: ______________
Relation: ______________
Home Phone: ______________
Cell Phone: ______________
Work Phone: ______________

Who is your medical doctor?
____

Medical Doctor's Phone:
____

MEDICAL HISTORY

Please check the box if you currently **have** or **have had** any of the following:

- ❑ Heart attack/stroke
- ❑ Heart surgery/pacemaker
- ❑ Heart murmur
- ❑ Rheumatic fever
- ❑ Mitral valve prolapse
- ❑ Artificial valves
- ❑ Heart disease
- ❑ Congenital heart defect
- ❑ Stomach problems/ulcers
- ❑ Jaw problems TMJ/TMD
- ❑ Cosmetic surgery
- ❑ X-ray/cobalt treatment
- ❑ Diabetes/hypoglycemia
- ❑ High/low blood pressure
- ❑ Thyroid problems
- ❑ Kidney problems
- ❑ Liver problems
- ❑ Respiratory problems
- ❑ Sinus problems
- ❑ Chest pains
- ❑ Psychiatric problems
- ❑ Venereal disease
- ❑ Alcohol/drug abuse
- ❑ Tuberculosis/TB
- ❑ Chemotherapy
- ❑ Anemia
- ❑ Leukemia
- ❑ Bleeding problems
- ❑ Cancer/tumors
- ❑ Shingles
- ❑ Hepatitis
- ❑ HIV+/AIDS/ARC
- ❑ Arthritis/rheumatism
- ❑ Artificial bones/joints
- ❑ Emphysema
- ❑ Fainting/seizures/epilepsy
- ❑ Severe/frequent headaches
- ❑ Frequent neck pain
- ❑ Back problems
- ❑ Asthma/difficulty breathing
- ❑ Scarlet fever
- ❑ Glaucoma
- ❑ Others conditions or surgeries: ____________________

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What medications are you taking? ❑ Nerve pills ❑ Pain killers (including aspirin)
❑ Tranquilizers ❑ Blood thinners ❑ Stimulants ❑ Muscle relaxers
❑ Insulin ❑ Medications for osteoporosis (in the last 7 years)

Please list any medications you are taking: ____________________

____

Do you require antibiotic pre-medication? ❑ Yes ❑ No
Are you allergic to any of the following? ❑ Latex ❑ Tetracycline
❑ Dental anesthetics ❑ Foods ❑ Penicillin ❑ Aspirin
❑ Others: ____________________

Do you use tobacco? ❑ Yes ❑ No
If so, how used?________________ How much?_________ How long?_____

Do you wear contact lenses? ❑ Yes ❑ No

For women: Are you taking birth control pills? ❑ Yes ❑ No
Are you pregnant? ❑ Yes ❑ No If so, how far along?______________
Are you nursing? ❑ Yes ❑ No

We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for all services rendered at the time of the visit, unless other arrangements have been made with the office manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges, and any other expenses incurred in collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims or to refer for specialty treatment.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature:____________________ **Date:**____________________

❑ Patient ❑ Parent or Guardian ❑ Spouse