PATIENT INFORMATION

Patients Date of Birth :_____
Patients Name:

First-_____Initial-_____

Last-_____

Nickname: _____

If Child:
Parents Name:_____

[] Single [] Married [] Separated
[] Divorced [] Widowed [] Minor

Home Address:
_____
_____

Home Phone:_____
Cell Phone: _____
Email:_____

Employed By:_____

Work Address:
_____
_____

Work Number:_____

Spouse/Parent Name:_____

Spouse Employed By:_____

Who is Responsible For Account:_____

Other Family in this Practice:
_____
_____

Social Security No.
Patient:_____
Spouse/Parent:_____

Emergency Contact:_____
Number :_____

Dental Insurance FIRST Coverage:

Employee Name:_____
Date of Birth:_____
Relationship to Patient:_____
Employer Name:_____
Name of Insurance company:
_____
Address:
_____
_____
Telephone:_____
Program or Policy #:_____
Social Security No.:_____
Union Local or Group # :_____

Dental Insurance SECOND Coverage:

Employee Name:_____
Date of Birth:_____
Relationship to Patient:_____
Employer Name:_____
Name of Insurance company:
_____
Address:
_____
_____
Telephone:_____
Program or Policy #:_____
Social Security No.:_____
Union Local or Group #:_____

[] No Insurance

How did you hear about us?
[] Family/Friend [] Phone book
[] Newspaper []Internet

Patient or Guardian's Signature
_____

Date:_____

Sandy Valley Dental Care
Joseph C. Wigfield D.D.S ~ (330)866-5555

MEDICAL HISTORY

Patient's Name: (F)_____(M)___ (L)_____ D.O.B._____

Physician's Name: _____ Date of last Exam: _____
Address:_____(Tel.)_____

Have you been hospitalized or had major surgery? List: _____.....Yes No
Do you take/taken, Phen-Fen or Redux?.....Yes No
Do you use any forms of Tobacco?.....Yes No
Do you regularly consume 1 or 2 alcoholic beverages a day?.....Yes No
Are you taking any medication or substances(vitamins)?.....Yes No
Please List _____
_____
_____

Are you allergic to any of the following?
[] Aspirin [] Penicillin [] Codeine [] Acrylic [] Metal [] Latex [] Local Anesthetics
[] Other.....Please List & Explain_____

Women:
Pregnant/Trying … Yes No Taking oral contraceptives … Yes No Nursing … Yes No

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

AIDS/HIV Positive.....Yes No
Anemia.....Yes No
Arthritis/Gout.....Yes No
Artificial Heart Valve.....Yes No
Artificial Joint.....Yes No
Asthma.....Yes No
Blood Disease.....Yes No
Cancer.....Yes No
Chemotherapy.....Yes No
Congenital Heart Disorder.....Yes No
Diabetes.....Yes No
Drug Addiction.....Yes No
Epilepsy/Seizures.....Yes No
Excessive Bleeding.....Yes No
Fainting Spells/Dizziness.....Yes No
Frequent Headaches.....Yes No
Heart Attack/Failure.....Yes No
Heart Murmur.....Yes No
Heart Pace Maker.....Yes No
Hepatitis A.....Yes No
Hepatitis B or C.....Yes No
Herpes.....Yes No
High Blood Pressure.....Yes No
Hives/Rash.....Yes No
Hypoglycemia.....Yes No
Kidney Problems.....Yes No
Leukemia.....Yes No
Liver Disease.....Yes No
Low Blood Pressure.....Yes No
Lung Disease.....Yes No
Mitral Valve Prolapse.....Yes No
Pain In Jaw Joints.....Yes No
Psychiatric Care.....Yes No
Radiation Treatments.....Yes No
Rheumatic Fever.....Yes No
Scarlet Fever.....Yes No
Shingles.....Yes No
Sinus Problems.....Yes No
Stomach Disease.....Yes No
Stroke.....Yes No
Thyroid Disease.....Yes No
Tuberculosis.....Yes No

Have you ever had any serious illness not listed above?_____
Comments:_____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT/ GUARDIAN'S SIGNATURE_____DATE_____

DENTIST SIGNATURE_____DATE_____

DENTAL HISTORY

Patient's Name (F)_____(M)____ (L)_____

Purpose of initial visit_____
Are you aware of a problem?_____
How long since your last dental visit?_____
What was done at that time?_____
Previous Dentist name_____
Address_____(Tel.)_____
Did you make regular visits? _____ Do you have Recent X-rays?_____
Do you have any questions or concerns?_____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S/GUARDIAN'S SIGNATURE _____DATE_____

DENTIST SIGNATURE _____DATE_____

CONSENT

I consent to the diagnostic procedures and treatment deemed necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or the records for which I am legal guardian) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or the records for which I am legal guardian) to the following persons. (Please list anyone authorized to discuss your treatment or records e.g. spouse, children, guardian.)

_____ _____

My consent to disclosure of records shall be effective until I revoke in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of service not paid, by my dental care payor.

I attest to the accuracy of the information on this consent section.

PATIENT/GUARDIAN'S SIGNATURE _____DATE_____