White Willow
FAMILY DENTAL
We listen. We care.

Patient Information

Patient's Name _____

Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Birthday _____ Social Security # _____

Cell Phone _____ Email address _____

Whom may we "Thank" for referring you to our practice: _____

Responsible Party Information

Name _____

Address _____
Street City State Zip

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Emergency Information

Person to contact / Relationship _____

Complete Address _____

Phone Home _____ Work _____ Cell _____

Dental Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group # _____ ID # _____

Insurance Company Address _____

Insured's Employer _____

Do you have dual (2nd) coverage? Yes _____ No _____ If Yes:

Insured's name _____ Insured's Soc. Sec.# _____

Insurance Co. _____ Group # _____ ID # _____

Insurance Co. Address _____

Insured's Employer _____

I hereby authorize the release of any information to my insurance company or companies, including records of examinations, diagnosis and/or treatment. This release is solely for facilitating the billing and reimbursement directly to White Willow Family Dental of insurance benefits under which I am entitled. I hereby agree that I am financially responsible for all treatment rendered, and understand that complete payment will be made after the treatment, unless other financial arrangements have been previously arranged. I assigned my insurance reimbursement directly to White Willow Family Dental and agree that I am responsible for any unpaid balance should my insurance deny reimbursement. Initial_____

Signature (Parent's signature if minor) _____

HEALTH HISTORY

The following information is very important and will aid us in caring for your dental needs.

CIRCLE

1. Are you having pain or discomfort at this time ..... YES NO
2. Have you ever fainted in a dental office? ..... YES NO
3. Have you had a serious accident or head injury ..... YES NO
4. Have you been a patient in the hospital during the past two years? ..... YES NO
   For what reason? _____
5. Do you smoke or chew tobacco ..... YES NO
6. Have you been under the care of a medical doctor during the past two years? ..... YES NO
7. Name of Physician _____
   Address _____ Phone _____
8. Have you taken any prescription medication or drugs during the past two years? ..... YES NO
9. Are you now taking any medication, drugs or pills? ..... YES NO
   If yes, please list: _____
   _____
10. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? ..... YES NO
    If yes, please list: _____
11. Indicate which of the following you have had or have at present. Circle "Yes" or "No" to each item .....

Heart Failure	YES NO	Emphysema	YES NO	Hepatitis B	YES NO
Heart Condition	YES NO	Persistant Cough	YES NO	Hepatitis (other)	YES NO
Atrial Fibrillation	YES NO	Tuberculosis (TB)	YES NO	Liver Disease	YES NO
Heart Attack	YES NO	Asthma	YES NO	Yellow Jaundice	YES NO
High Blood Pressure	YES NO	COPD	YES NO	Blood Transfusion	YES NO
Mitral Valve Prolapse	YES NO	Sinus Trouble	YES NO	Alcohol or Drug Addiction	YES NO
Heart Murmur	YES NO	Diabetes	YES NO	Hemophilia	YES NO
Rheumatic Fever	YES NO	Thyroid Disease	YES NO	Venereal Disease	YES NO
Congenital Heart Lesions	YES NO	RadiationTherapy	YES NO	Cold Sores / Fever Blisters	YES NO
Scarlet Fever	YES NO	Chemotherapy (Cancer, Leukemia)	YES NO	Epilepsy or Seizures	YES NO
Artificial Heart Valve	YES NO	Arthritis	YES NO	Fainting or Dizzy Spells	YES NO
Heart Pacemaker	YES NO	Rheumatism	YES NO	Nervousness	YES NO
Heart Surgery	YES NO	Cortisone Medicine	YES NO	Depression	YES NO
Artificial Joints (Hip, Knee)	YES NO	Anticoagulant Medicine	YES NO	Psychiatric Treatment	YES NO
Anemia	YES NO	Glaucoma	YES NO	Sickle Cell Disease	YES NO
Stroke	YES NO	Pain in Jaw Joints	YES NO	Allergies to Jewelry	YES NO
Kidney Trouble	YES NO	A.I.D.S.	YES NO	Dementia	YES NO
Stomach Ulcers	YES NO	HIV Positive	YES NO	Parkinson's	YES NO
Cosmetic Surgery	YES NO	Hepatitis A (infectious)	YES NO	Alzheimer's	YES NO
Mouth Ulcers	YES NO				

12. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? ..... YES NO
13. Have you been diagnosed with sleep apnea? ..... YES NO
14. Do you have a history of periodontal disease? ..... YES NO
15. Do you ever wake up from sleep short of breath? ..... YES NO
16. Are you on a special diet? ..... YES NO
17. Has your medical doctor ever said you have a cancer or tumor? ..... YES NO
18. Do you have any disease, condition or any other information concerning your health that we should know about ..... YES NO

Please describe _____

Are you pregnant? ❑ YES ❑ NO If yes, what month? _____

Are you nursing? ❑ YES ❑ NO

Reviewed by _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I verify that the above information is true and correct to the best of my belief. I thereby authorize White Willow Family Dental and their staff to perform for me and/or my dependents such dental treatment, medication or therapy as they deem appropriate and in connection therewith to take or prepare x-rays, models or other diagnostic aids. I acknowledge that the performance of dental services (especially the use of anesthetic) inherently involves some risk.

Patient _____ Date _____

Parent or Responsible Party _____ Relationship to Patient _____