



Wall Street Dental

Date ____/____/____

Contact Information

Patient Last Name _____ First _____ Middle Initial _____ Nickname _____

Home Phone _____ Work Phone _____ Cell Phone _____ SSN# _____

Address _____ City _____ State _____ Zip _____ E-mail _____

Birthdate _____ Age _____ Married _____ Partnered _____ Single _____ Divorced _____ Separated _____ Widowed _____

If Married, Spouse's Name _____ Their Work Phone _____ Cell Phone _____

Grade if Student _____ School _____

Occupation _____ Employer _____ Employer's phone _____

Employer's address _____ City _____ State _____ Zip _____

Person Responsible for Bill _____

Address _____ City _____ State _____ Zip _____

It is okay to contact me by: Home Phone _____ Work Phone _____ Cell Phone _____ Text _____ E-mail _____

May we leave a message regarding dental information at any of the above checked #'s? Yes _____ No _____

If yes, which #'s Home _____ Work _____ Cell _____ Other _____

INSURANCE INFORMATION

Do You Have Dental Coverage? Yes _____ NO _____

Primary Insurance

Insured Person's Name _____ DOB _____ SS# _____

Insured's Address _____ City _____ State _____ Zip _____

Insured's Home Phone _____ Work Phone _____ Cell Phone _____ E-mail _____

Relationship to Patient _____ Insurance Co. Name _____

Insurance Co. Address _____ City _____ State _____ Zip _____

Insurance Co. Phone _____ Group# (Plan, Local or Policy#) _____

Insured's Employer _____ Employer's Phone _____

Employer's Address _____ City _____ State _____ Zip _____

Secondary Insurance

Insured Person's Name _____ DOB _____ SS# _____
Insured's Address _____ City _____ State _____ Zip _____
Insured's Home Phone _____ Work Phone _____ Cell Phone _____ E-mail _____
Relationship to Patient _____ Insurance Co. Name _____
Insurance Co. Address _____ City _____ State _____ Zip _____
Insurance Co. Phone _____ Group# (Plan, Local or Policy#) _____
Insured's Employer _____ Employer's Phone _____
Employer's Address _____ City _____ State _____ Zip _____

GETTING TO KNOW YOU

- 1. Why did you select our office? _____
- 2. Whom may we thank for referring you? _____
- 3. Is another member of your family a patient in our practice? (please list name(s))

- 4. Person for emergency contact _____ Phone#'s _____ Relationship _____
- 5. When was your last dental visit? _____ When was the last time you had dental radiographs taken? _____
- 6. Name of last dentist _____ City _____ State _____ Phone _____
- 7. Have you ever had any teeth removed? _____ How long have the teeth been missing? _____
Have these teeth been replaced _____ How? Bridge ___ Partial ___ Denture ___ Implants ___

Receipt of Forms (please check if you agree)

- ___ I have received and read the Welcome to Wall Street Dental letter.
- ___ I have received and read a Notice of Privacy Practices.
- ___ I have received a VIP Express Checkout form.
- ___ I have received and read a Financial Policies form.
- ___ I have completed and signed the Medical History Form.
- ___ I have read and signed the Dental Information and Acceptance Form.

MEDICAL HISTORY

1. Why have you come to the dentist today? _____
2. How do you feel about getting and maintaining a healthy mouth? _____
3. If you could change anything about your smile, what would you change? _____
4. Are you in pain? Yes___ No___
5. Do you require antibiotics before dental work? Yes___ No___
6. Your current dental health is: Good___ Fair___ Poor___
7. Have you ever had a serious/difficult problem associated with previous dental work? Yes___ No___
8. Do you floss daily? Yes___ No___
9. Do you brush daily? Yes___ No___
10. Type of bristles you use on your teeth Hard___ Medium___ Soft___
11. Have you ever had gum treatment? Yes___ No___
12. Do your gums ever bleed Yes___ No___
13. Have you ever had periodontal disease Yes___ No___
14. Do you have or have you ever had pain or discomfort in your jaw joint? Yes___ No___
15. Are your teeth sensitive to heat, cold or anything else? _____
16. Do you have any loose teeth? Yes___ No___
17. Do you still have your wisdom teeth Yes___ No___
18. Would you like fresher breath? Yes___ No___
19. Would you like whiter teeth? Yes___ No___
20. Are you happy with the way your smile looks? Yes___ No___
21. Are you nervous about having dental treatment? Yes___ No___
22. Have you ever had a bad experience in a dental office? Yes___ No___
23. Do you have a personal physician Yes___ No___
Physician's name _____ Phone# _____
24. Your current health is: Good___ Fair___ Poor___
25. Are you currently under the care of a physician? Yes___ No___ If so, explain: _____
26. Have you been in the hospital in the past 2 years? Yes___ No___ If so, explain: _____

27. Are you taking any prescription or over the counter drugs? Yes___ No___ If so, please list:

28. Are you allergic to (i.e. itching, rash, swelling of hands, feet or eyes) or been made sick by penicillin, latex, aspirin, codeine or any other drugs or medications? If so, please list_____
29. Have you ever had excessive bleeding requiring special treatment? Yes___ No___
30. Do you use tobacco products? Yes___ No___
31. When you walk up stairs or take a walk do you have to stop because of chest pain, shortness of breath, or because you are tired? Yes___ No___
32. Do your ankles swell during the day? Yes___ No___
33. Have you gained or lost more than 10 pounds in the past year? Yes___ No___
34. Do you use more than 2 pillows to sleep? Yes___ No___
35. Do you ever wake up from sleep short of breath Yes___ No___
36. Do you snore loudly or hold your breath when you sleep? Yes___ No___
37. Are you on a special diet? Yes___ No___
38. Hsve you ever taken Pen-Fen? (also known as Redux or Pondimin Yes___ No___
39. Have you ever taken Fosamax or any other bisphosphonate? Yes___ No___
40. For women: Are you pregnant? Yes___ No___ Week#___ Are you nursing___

Check any of the following which apply in either past or present:

<input type="checkbox"/> Heart Valve Prolapse	<input type="checkbox"/> Anemia	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Asthma	<input type="checkbox"/> Pain in Jaw Joints
<input type="checkbox"/> Heart Disease or Attack	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Radiation Treatment
<input type="checkbox"/> Angina Pectoris	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Cancer or Tumors
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Chemotherapy
<input type="checkbox"/> Congenital Heart Lesions	<input type="checkbox"/> Allergies or Hives	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Fainting or Dizzy Spells	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> HIV Positive (AIDS)
<input type="checkbox"/> Heart Pacemaker	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Heart Surgery	<input type="checkbox"/> Psychiatric Treatment	<input type="checkbox"/> Cold Sores or Fever Blisters
<input type="checkbox"/> Artificial Joint of Any Kind	<input type="checkbox"/> Eating Disorders	<input type="checkbox"/> Kidney Problems
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Drug/Alcohol Addiction	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Tuberculosis (TB)	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Any Form of Hepatitis	<input type="checkbox"/> Stroke

<input type="checkbox"/> Sickle Cell Disease	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Birth Control Medications
<input type="checkbox"/> Shogren's Syndrome	<input type="checkbox"/> Rheumatism	<input type="checkbox"/> Frequent Headaches
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Cortisone Medication	<input type="checkbox"/> Sinus Problems

Do you have any disease, condition or problem not listed? If so, please list _____

For All Patients:

I hereby authorize the doctor to perform any form of treatment that may be indicated in connection with my/my child or guardianship's dental care. I also understand that prior to treatment; full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office and hereby consent to the release of information for the purpose of payment (i.e. insurance). I further understand that a 15% finance charge will be added to any balance over 90 days. In the event of default, I/we promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Signature of Responsible Party

Relationship

Date

Witness

Our Office is HIPAA Complaint and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.