

William L. Walden DDS

NAME \_\_\_\_\_ Birth date: \_\_\_\_\_ Social Security no. \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

HOW OR WHO REFERRED YOU TO OUR OFFICE \_\_\_\_\_

PHONES: Work \_\_\_\_\_ Home \_\_\_\_\_ e-mail \_\_\_\_\_

Cell: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ EMPLOYER & address \_\_\_\_\_

Spouse's OCCUPATION \_\_\_\_\_ EMPLOYER & address \_\_\_\_\_

Does patient have dental insurance? \_\_\_\_\_ Name of Insurance Co \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ ID #: \_\_\_\_\_

ACCOUNT RESPONSIBILITY if someone other than yourself: NAME \_\_\_\_\_

Mailing Address \_\_\_\_\_ Daytime Phone \_\_\_\_\_

HEALTH HISTORY (please check if you have or had any of the following :)

- Yes  No Are you in good health?
- Yes TB, asthma or lung disease \_\_\_\_\_
- Yes Chest pain, shortness of breath \_\_\_\_\_
- Yes Bleeding problems, bruise easily \_\_\_\_\_
- Yes Stroke \_\_\_\_\_
- Yes Heart valve defect \_\_\_\_\_
- Yes Fainting or seizures \_\_\_\_\_
- Yes Heart disease, murmurs, rheumatic fever, \_\_\_\_\_
- Yes Pacemaker \_\_\_\_\_
- Yes High Blood pressure \_\_\_\_\_
- Yes Hepatitis or liver disease \_\_\_\_\_
- Yes Has your health changed in the last year \_\_\_\_\_

- Yes Diabetes \_\_\_\_\_
- Yes Tumors, cancer \_\_\_\_\_
- Yes Radiation treatment \_\_\_\_\_
- Yes Psychiatric care \_\_\_\_\_
- Yes Kidney or bladder disease \_\_\_\_\_
- Yes Joint pain or stiffness, arthritis \_\_\_\_\_
- Yes HIV positive, AIDS, ARC \_\_\_\_\_
- Yes Pregnant: month \_\_\_\_\_
- Yes Birth control Pills \_\_\_\_\_
- Yes Headaches, ringing in ears \_\_\_\_\_
- Yes Hip or knee implant Year \_\_\_\_\_

List any and all ALLERGIES: \_\_\_\_\_

List any and all DRUGS/MEDICATIONS you are taking: \_\_\_\_\_

\_\_\_\_\_

List any and all SURGERIES \_\_\_\_\_

List any ill effects from Novocane, Penicillin or any other drugs \_\_\_\_\_

Have you experienced any unfavorable reaction from previous dental treatment? \_\_\_\_\_

Yes  No Are you being treated by a Physician now? Who? \_\_\_\_\_

The above information is true and correct to the best of my knowledge:

PATIENT OR GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_