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

!. 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 competed 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:

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

○	Sickle Cell Disease	○	Liver Disease	○	Birth Control Medications
○	Shogren's Syndrome	○	Rheumatism	○	Frequent Headaches
○	High Blood Pressure	○	Cortisone Medication	○	Sinus Problems

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

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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.