Warwick
DENTAL GROUP

We would like to get to know you better!

Date ___________

Name ____

Residence ____________________________________ Zip ___________

Home Phone ____________________ Cell Phone ____________________

Email Address ____

Social Security # ____________________ Occupation ____________________

Employer ____

Address ____________________________________ Phone ___________

Date of Birth ____________________

Spouse's Name ____________________ Spouse's Occupation ____________________

Employer ____

Address ____________________________________ Phone ___________

Who referred you to our office? ____

Person responsible for dental investment ________________________________

For Insurance Purposes

Name of Carrier ____

Social Security # ____________________ Group # ____________________

Are you covered by another plan? __________

If so, Name of Carrier ____

Social Security # ____________________ Group # ____________________

Medical History

Name of Physician ______________________________

Date of last physical exam ______________________________

Do you have or have you ever had any of the following: (Please mark the appropriate column)

	Currently	In the Past	Never Had
Anemia	☐	☐	☐
Asthma	☐	☐	☐
Diabetes	☐	☐	☐
If currently diabetic, are you insulin dependant? Y N			
Tuberculosis	☐	☐	☐
Sinus Problems	☐	☐	☐
Fen/Phen or other prescription weight loss drugs	☐	☐	☐
Kidney Disease	☐	☐	☐
Radiation Treatment	☐	☐	☐
Cancer	☐	☐	☐
High Blood Pressure	☐	☐	☐
Heart Attack, Heart Surgery or Heart Disease	☐	☐	☐
Congenital Heart Disease	☐	☐	☐
Mitral Valve Prolapse	☐	☐	☐
Pacemaker or Artificial Heart Valve	☐	☐	☐
Any Prosthetics	☐	☐	☐
If currently, when/where were they placed? ______________________________			
Rheumatic Fever	☐	☐	☐
Heart Murmur	☐	☐	☐
If currently, have you ever been told that you should premedicate? Y N			
Stroke	☐	☐	☐
Dizziness or Fainting	☐	☐	☐
Convulsions/Epilepsy	☐	☐	☐
Psychiatric Treatment	☐	☐	☐
Hepatitis (circle type) A B C	☐	☐	☐
Any Contagious diseases	☐	☐	☐
Venereal Disease	☐	☐	☐
AIDS or HIV+ test result	☐	☐	☐
Latex sensitivity	☐	☐	☐
Allergies to any metals or minerals?	☐	☐	☐

Are there any diseases or conditions not listed above that you have been diagnosed with? Y N

If yes, please explain: ______________________________

Have you had joint replacement within the last two years? Y N

If yes, what time and when? ______________________________

Are you pregnant or think you may be pregnant? Y N

If yes, what is your due date? ______________________________

Are you nursing? Y N

Are you taking any medications?

(This includes prescription, over-the-counter, or herbal medicines) Y N

Please list all medications including dosage and frequency: ______________________________

____

____

____

Are you taking any medications for the treatment of osteoporosis, bone pain or bone disease? Y N

____

Any allergies or adverse reactions to: (please circle)

Penicillin Aspirin Sulfa Drugs Latex Local Anesthetic Other (Please list below)

____

Are you under a physician's care now? Y N ______________________________

Please list any surgeries you have had: ______________________________

Have you been hospitalized for any reason within the past five years? Y N

If yes, please explain: ______________________________

To the best of my knowledge, all of the preceding answers on both sides of this form are true and correct. If I ever have a change in my health or medications, I will inform the dentist at the next appointment.

Signature of Patient, Parent or Guardian:

______________________________ Date: ______________

Oral Hygiene History

Last Dental Visit ______________________

Were radiographs (xrays) taken at that visit? Y N

When was your last full mouth set of radiographs (xrays) taken? ______________________

Do you have or have you ever had any of the following: (Please mark the appropriate column)

	Currently	In the Past	Never Had
Bleeding or Sore Gums	☐	☐	☐
Unpleasant taste in mouth or bad breath	☐	☐	☐
Burning tongue or lips	☐	☐	☐
Frequent blisters on lips or mouth	☐	☐	☐
Swelling or lumps in mouth	☐	☐	☐
Orthodontic treatment (braces)	☐	☐	☐
Biting cheeks or gums	☐	☐	☐
Clicking or popping jaws	☐	☐	☐
Use of tobacco products	☐	☐	☐
Loose teeth	☐	☐	☐
Sensitivity to hot and/or cold	☐	☐	☐
Sensitivity to sweets	☐	☐	☐
Pain while biting or chewing	☐	☐	☐
Food caught between teeth	☐	☐	☐
Changes in bite	☐	☐	☐
Cold sores, blisters or oral lesions	☐	☐	☐
Snore or have any other sleep disorders	☐	☐	☐
Do you have/use a CPAP device?	☐	☐	☐

Are you satisfied with your teeth's appearance?

Would you like to keep all of your teeth all of your life?	YES	NO
Do you feel nervous about having dental treatment?	YES	NO
If so, what is your biggest concern? ______________________		
Have you ever had an upsetting dental experience?	YES	NO
If so, please describe ______________________		
Do you ever avoid any part of the mouth while brushing?	YES	NO
Are you deeply concerned about the finances required to return your mouth to excellent dental health?	YES	NO
Do you get frustrated because you always have something to be treated or repaired when you visit a dentist?	YES	NO
Do you want to learn to control dental disease and retain your teeth?	YES	NO
Have you ever had any teeth removed?	YES	NO
How long have these teeth been missing? ______________________		
Do you feel you will eventually wear artificial dentures?	YES	NO
Have you had a reaction to local anesthetic?	YES	NO