DENTAL & MEDICAL SPA
WINDERMERE

Welcome to Our Office!

To help us meet all your healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Name _____ Date _____

Soc. Sec. # _____ Birthdate_____ Age _____ Sex _____

Cell #_____ Home # _____ Email _____

Address_____ City_____ State _____ Zip _____

Driver's License #_____ State _____ Expiration date _____

Emergency Contact _____ Relationship _____ Phone_____

When confirming appointments how do you prefer to be contacted? ❑ Phone ❑ Email ❑ Text Message

How did you hear about our office? (Check All That Apply)

❑ Mail ❑ Google ❑ Website ❑ Yellow Pages ❑ Drive By ❑ Brochure ❑ Friend or Patient _____

Responsible Party

Name of Person Responsible for this Account _____

Relationship to Patient _____ Contact # _____

Birthdate _____ Employer _____

Billing Address_____ City_____ State ____ Zip _____

Work Phone_____ Cell Phone _____ SSN # _____

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security# _____ Date Employed_____

Name of Employer _____ Work Phone _____

Insurance Company _____ Group #_____ Policy/ID_____

Ins. Co. Address _____ City_____ State____ Zip_____

Patient Medical History

Primary Care Physician _____ Office Phone_____

1.Are you under medical treatment now? NO/YES, please explain_____

_____

2. Have you ever been hospitalized for any surgical operations or serious illnesses within the last 5 years? NO/YES, please explain _____

3. Are you taking any medication(s) including non-prescription medicine? NO/YES, if so please list what medications are you taking? _____

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4. Are you currently taking, or have you ever taken osteoporosis medications? NO/YES, if so for how long:_____ Reason: _____ Medication: _____

5. Do you use Tobacco? NO/YES 6. Do you use controlled substances or recreational drugs? NO/YES

7. Are You **Allergic** to any medications? NO/YES, please explain _____

8. Have you ever had a reaction to any of the following?

❑ Local anesthetics
❑ Antibiotics
❑ Sulfa drugs
❑ Barbiturates or sleeping pills
❑ Aspirin, Acetaminophen, or Ibuprofen
❑ Codeine, Demerol, or other narcotics
❑ Reaction to metals
❑ Latex or Rubber
❑Other_____
_____

9. Do you have, or have you had any of the following? (Please check all that apply)

❑ Heart problems
❑ Chest pain
❑ Blood pressure problems
❑ Heart murmur
❑ Rheumatic fever
❑ Pacemaker
❑ Artificial heart valve
❑ Bruises easily
❑ Frequent nosebleeds
❑ Anemia
❑ Allergy problems
❑ Hay fever
❑ Sinus problems
❑ Skin rashes
❑ Asthma
❑ Intestinal Problems
❑ Ulcers
❑ Weight gain/loss
❑ Constipation/ Diarrhea
❑ Kidney or bladder problems
❑ Arthritis
❑ Back or neck pain
❑ Joint replacement _____
❑ Fainting, seizures or epilepsy
❑ Stroke
❑ Headaches/ Migraines
❑ Thyroid problems
❑ Persistent cough or swollen glands
❑ Cancer/ Tumor
❑ Diabetes
❑ Tuberculosis
❑ Hepatitis, jaundice, or liver trouble
❑ Herpes virus
❑ STD _____
❑ HIV-positive/ AIDS
❑ Glaucoma
❑ History of head injury
❑ Epilepsy or other neurological disease
❑ Other_____
_____

Women Only:

a) Are you pregnant? NO/YES, _____weeks
b) Are you taking contraceptives or hormones? NO/ YES, _____
c) Are you Nursing? NO/YES
d) Have you reached Menopause? NO/YES, if so are you having symptoms? _____

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Patient Dental History

Previous Dentist _____

Date of Last Exam/Cleaning _____

1. Are you apprehensive about dental treatments or procedures? No❑ Yes ❑
2. Have you had problems with previous dental treatments? No❑ Yes ❑
3. Does food catch between your teeth? No❑ Yes ❑
4. Do you have difficulty chewing your food? No❑ Yes ❑
5. Do you chew on only one side of your mouth? No❑ Yes ❑
6. Do your gums bleed easily? No❑ Yes ❑
7. Do your gums bleed when you floss? No❑ Yes ❑
8. Are your teeth sensitive? No❑ Yes ❑
9. Do you feel discomfort when your teeth come in contact with hot/cold? No❑ Yes ❑
10. Are you dissatisfied with the appearance of your teeth? No❑ Yes ❑
11. How often do you brush? _____
12. How often do you floss? _____
13. Do you clench or grind your teeth frequently? No❑ Yes ❑
14. Do your jaws ever feel tired? No❑ Yes ❑
15. Does your jaw get stuck closed? No❑ Yes ❑
16. Do you have earaches or pain in front of ears? No❑ Yes ❑
17. Do you have a temporomandibular (jaw) disorder (TMD)? No❑ Yes ❑
18. Do you require medication before dental procedures? No❑ Yes

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Authorization and Release: I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I agree to be responsible for payment of all service rendered on behalf of myself and/ or on the behalf of my dependents.

Patient/Guardian signature _____ Date _____

Print name _____ Relationship _____