WILDEWOOD
AESTHETIC DENTISTRY

Name:_____ Preferred:_____ Consent Date:_____

Email Address _____

Address:_____City _____ ST_____Zip_____

Home Phone:_____ Work Phone:_____ Mobile:_____

Date of Birth:_____ Social Security #_____

Marital Status: ❒Married ❒Single ❒Divorced ❒Separated

Dental Insurance Carrier:_____

Insurance Address_____Ins. Phone #_____

Insurance ID # _____ Group # _____

Insurance Subscriber's Name:_____Subscriber's DOB_____

How did you hear about our practice?_____

Yes No Have you been a patient in the hospital during the last two years?
Yes No Have you been under care of a medical doctor during the past two years?
Yes No Have you ever had any excessive bleeding requiring special treatment?
Yes No Are you allergic to (i.e., itching, rash, swollen hands, feet, or eyes) or made sick by penicillin or latex?
Yes No Do you have shortness of breath, chest pain, or get extremely tired when walking up one flight of stairs?
Yes No Do your ankles swell up during the day?
Yes No Do you smoke? If so, how many packs a day? _____
Yes No WOMEN: Is there a possibility you are pregnant now?
Yes No Do you snore?
Yes No Do you have daytime sleepiness?

Please circle the following medication that you have taken in the past two years:

Anticoagulants	Aspirin	Nitroglycerin	Cortisone medicine
Antihistamines	Antidepressants	Anti-hypertensive Meds	Diuretics
Insulin	Chemotherapy	X-ray/Cobalt Therapy	Contraceptive Pills
Phen-Fen	Fosamax	Arthritic Medication	St. John's Wort

Please list all medications taken (include supplements):

_____

_____

Have you ever had any of the following?

Yes No Heart Disease or Attack	Yes No High Blood Pressure	Yes No Venereal Disease	Yes No Fainting/Dizzy Spells
Yes No Cancer or Leukemia	Yes No Bruise Easily	Yes No Sleep Apnea	Yes No Epilepsy or Seizures
Yes No Heart Murmur	Yes No Tumors	Yes No Thyroid Disease	Yes No COPD/Emphysema
Yes No Artificial Heart Valve	Yes No Arthritis or Rheumatism	Yes No Hepatitis	Yes No Hay Fever
Yes No Congenital Heart Disease	Yes No Pain in Jaw Joints(TMJ)	Yes No Persistent Cough	Yes No Allergies or Hives
Yes No Implants(Joint/Knee, etc.)	Yes No Liver Disease	Yes No Tuberculosis (TB)	
Yes No Kidney Trouble	Yes No HIV or AIDS	Yes No Asthma	
Yes No Heart Pacemaker	Yes No Diabetes	Yes No Blood Transfusion	
Yes No Heart Surgery	Yes No Glaucoma	Yes No Hemophilia	
Yes No Angina Pectoris	Yes No Psychiatric Care	Yes No Drug/Alcohol Dependent	
Yes No Stroke	Yes No Frequent Cold Sores	Yes No Anemia	

Do we have permission to contact your physician regarding items on this form or regarding any information that will aid us in your treatments? Yes No Physician's Name and Number: _____

To the best of my knowledge, all of the above answers are true and correct. If I ever have any change in my health condition, I will inform this office at the next appointment. I give my informed consent for the dental team to perform dental services

Date: _____Signature: _____