Waverly Family Dentistry

HEALTH HISTORY

Date _____

Patient Name _____ Name you wish to be called _____

Physical Address _____ Home Phone _____

City _____ State _____ Zip Code _____ Work Phone _____

Mailing Address _____ Cell Phone _____

City _____ State _____ Zip Code _____ Email _____

Best Time and Place to Reach You Live and In Person _____

Sex: ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS # _____ Occupation _____ Employer _____

Employer Address _____ Employer Phone _____

Spouse Name _____ Birthdate _____

IN CASE OF EMERGENCY PLEASE CONTACT

Name _____ Relationship to You _____

Address and Phone Number of Emergency Contact Person _____

_____

Whom may we thank for referring you? _____

Who is responsible for this account? _____ Relationship to Patient _____

DENTAL INSURANCE INFORMATION

Primary Insurance Company _____ Group # _____

Subscriber's Name _____ SS # _____

Birthdate _____ Relationship to Patient _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Secondary Insurance Company _____ Group # _____

Subscriber's Name _____ SS # _____

Birthdate _____ Relationship to Patient _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with
and assign directly to doctor otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

→ _____ _____ _____

Responsible Party Signature | Relationship | Date

DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____ City/State _____

Date of last dental visit _____ Date of last dental X-rays _____

How often do you brush? _____

How often do you floss? _____

Type of bristles on your toothbrush? ☐ Hard ☐ Medium ☐ Soft

Have you ever had a serious or difficult problem associated with previous dental work? ☐ Yes ☐ No

DENTAL HISTORY (continued)

Please check YES or NO to indicate if you have had any of the following:

Dry mouth	☐ Yes	☐ No	Sensitivity to cold/hot	☐ Yes	☐ No	Cigarette, pipe or cigar smoking	☐ Yes	☐ No
Bad breath or bad taste in mouth	☐ Yes	☐ No	Sores or growths in your mouth	☐ Yes	☐ No	Do you or have you ever experienced pain/discomfort in your jaw joint	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No	Chewing tobacco	☐ Yes	☐ No			

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

☐ Yes ☐ No Have you been hospitalized within the last 2 years? Please explain _____

☐ Yes ☐ No Are you currently being treated by a physician? Please explain _____

☐ Yes ☐ No Do you bleed excessively upon injury?

☐ Yes ☐ No Are you currently taking birth control pills?

☐ Yes ☐ No Are you pregnant? If yes, how many weeks? _____

☐ Yes ☐ No Are you nursing?

Please check box to indicate if you have had or now have any of the following conditions:

☐ AIDS/HIV	☐ Epilepsy	☐ Jaundice	☐ Reflux/Heartburn
☐ Arthritis	☐ Glaucoma	☐ Kidney Problems	☐ Rheumatic Fever
☐ Artificial Joint	☐ Heart Attack	☐ Low Blood Pressure	☐ Seizures
☐ Asthma	☐ Heart Problem	☐ Mental Health Disorder	☐ Sexually Transmitted Disease
☐ Cancer	☐ Heart Valve Replacement	☐ Osteoporosis	☐ Stroke
☐ Diabetes		☐ Pacemaker	☐ Tuberculosis
☐ Eating Disorder	☐ Hepatitis	☐ Radiation/Chemotherapy	☐ Ulcers
	☐ High Blood Pressure		

☐ Other? Please specify _____

ALLERGIES

☐ Aspirin
☐ Antibiotics
Specify: _____
☐ Codeine
☐ Iodine
☐ Latex
☐ Local Anesthetic
☐ Metals (jewelry)
☐ Other _____
_____

MEDICATIONS

Please list medications you are currently taking:

_____
_____
_____
_____

Pharmacy Name _____

I understand that I may be charged a 1.5% finance charge per month (18% annually) if my balance goes beyond 90 days.

I give permission for my dentist and clinical team to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my dental needs. I also give permission for my dentist and dental team to use my photographs for in-office patient education.

I consent to the use and disclosure of my protected health information to obtain payment information in connection with my dental claims.

→ _____ _____

Patient or Guardian's Signature Date

Clinical Team - Reviewed By: _____