FOR OFFICE USE ONLY
PATIENT NO.:

Please complete all information on this form.

______________________________ ☐ Male ☐ Female
Full Legal Name *(Please Print First, Middle and Last)*

____
Residential Address

____
City State ZIP

____
Date of Birth Height Weight Age Home Phone Cell Phone

____
Occupation Employer

____
Business Phone Email

DENTAL HISTORY

Do you have any Major Medical Problems? ☐ Yes ☐ No

Please Explain: ______________________________

____

☐ Yes ☐ No Is there any chance you could be pregnant?

☐ Yes ☐ No Are you currently taking, or have you even taken any Bisphosphonates or other medication for osteoporosis?

Please list current or past prescribed Bisphosphonate drug*(s)* - for example, Boniva, Fosamax, Skelid:

____

☐ Yes ☐ No Have you even been treated for periodontal gum disease?

☐ Yes ☐ No Do you have a family dentist?

Dentist's Name: ______________________________

Last Visit: ______________________________

What is you main dental concern today? ______________________________

How is your current dental condition affecting you? ______________________________

How would treating your dental condition change your life? ______________________________

How soon would you like to start your dental treatment? ______________________________

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Please complete all information on this form.

I, ______________________________, give Wellness Dental Family & Cosmetic Dentistry permission to leave information pertaining to:

- Appointment Information
- Treatment Information
- Healthcare Financing Information
- Referral Information
- Test Results

Please consider carefully where we can leave voicemail messages and whom you want to have access to your medical information.

Contact Information:
Please complete all the information and **select which option you prefer**.

☐ Daytime phone number (7am-5-pm): ________________________ ☐ No Voicemail
☐ Evening phone number (after 5pm): ________________________ ☐ No Voicemail
☐ Weekend phone number (Sat & Sun): ________________________ ☐ No Voicemail
☐ Email: ____

My medical care may be discussed with the person(s) listed below:

____ Relationship __________________________________
____ Relationship __________________________________

Is someone accompanying you? ☐ Yes ☐ No Name and Relation: __________________________________

Please initial permission for
WORK TO BE DONE:

Consult ________ initials

3D X-Ray ________

initials Panoramic x-ray ________

initials

Signature of Patient/Guardian ____ **Date** ________________