WAVERLY DENTAL

PATIENT NAME: **SEX:** **DATE OF BIRTH:** **S.S.#** **INSURANCE ID#**

PREFFERED NAME: **PHONE NO: (HOME):** **(CELL):** **(WORK):**

ADDRESS: **APT/UNIT NO:** **CITY:** **STATE:** **ZIPCODE:**

PARENT/SPOUSE'S NAME: **DOB:** **E-MAIL ADDRESS:**

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED, BESIDES PERSON LISTED ABOVE? **PHONE NUMBER:**

WHOM MAY WE THANK FOR REFERRING YOU?

FEMALES: ARE YOU PREGNANT OR TRYING TO GET PREGNANT? **IF SO, DUE DATE:** **ARE YOU NURSING?**

NAME OF OB/GYN: **PHONE NO:** **ARE YOU TAKING ORAL CONTRACEPTIVES?**

LIST ANY MEDICATIONS, NOTING REASON, DOSEAGE & FREQUENCY (USE SEPARATE PAGE IF TOO MANY TO LIST):

HAVE YOU HAD MAJOR SURGERY OR BEEN HOSPITALIZED IN THE PAST FIVE YEARS? **REASON/ DATE:**

HAVE YOU EVER HAD A SERIOUS HEAD OR NECK INJURY?

ARE YOU UNDER A PHYSICIAN'S CARE NOW: **IF SO, PLEASE EXPLAIN:**

PHYSICIAN'S NAME/PHONE NUMBER: **DATE OF LAST PHYSICAL EXAM:**

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING? **ASPIRIN:** **PENICILLIN:** **CODEINE:** **LATEX:**

SULFA DRUGS: **LOCAL ANESTHESIA:** **ACRYLIC:** **FOOD/OTHER ALLERGY: <explain>**

DOES PATIENT HAVE, OR HAS EVER HAD, ANY OF THE FOLLOWING?

DOES PATIENT USE TOBACCO PRODUCTS? □ YES □ NO

	YES	NO		YES	NO		YES	NO		YES	NO
AIDS/HIV POSITIVE	□	□	CORTISONE MEDICINE	□	□	HEMOPHELIA	□	□	RADIATION TREATMENTS	□	□
ALZHEIMER'S	□	□	DIABETES	□	□	HEPATITIS A	□	□	RECENT WEIGHT LOSS	□	□
ANAPHYLAX	□	□	DRUG ADDICTION	□	□	HEPATITIS B or C	□	□	RENAL DIALYSIS	□	□
ANEMIA	□	□	EASILY WINDED	□	□	HERPES	□	□	RHEUMATIC FEVER	□	□
ANGINA	□	□	EMPHYSEMA	□	□	HIGH BLOOD PRESSURE	□	□	RHEUMATISM	□	□
ARTHRITIS/GOUT	□	□	EPILEPSY OR SEIZURES	□	□	HIGH CHOLESTEROL	□	□	SCARLET FEVER	□	□
ART.HEART VALVE	□	□	EXCESSIVE BLEEDING	□	□	HIVES OR RASH	□	□	SHINGLES	□	□
ARTIFICIAL JOINT	□	□	EXCESSIVE THIRST	□	□	HYPOGLYCEMIA	□	□	SICKLE CELL DISEASE	□	□
ASTHMA	□	□	FAINTING /DIZZINESS	□	□	IRREGULAR HEARTBEAT	□	□	SINUS TROUBLE	□	□
BLOOD DISEASE	□	□	FREQUENT COUGH	□	□	KIDNEY PROBLEMS	□	□	SPINA BIFADA	□	□
BLOOD TRANS	□	□	FREQUENT DIARRHEA	□	□	LEUKEMIA	□	□	STOMACH/INTEST DISEASE	□	□
BREATHING PROBLEMS	□	□	FREQUENT HEADACHE	□	□	LIVER DISEASE	□	□	STROKE	□	□
BRUISE EASILY	□	□	GENITAL HERPES	□	□	LOW BLOOD PRESSURE	□	□	SWELLING OF LIMBS	□	□
CANCER	□	□	GLAUCOMA	□	□	LUNG DISEASE	□	□	THYROID DISEASE	□	□
CHEMOTHERAPY	□	□	HAY FEVER	□	□	MITRAL VALVE PROL	□	□	TONSILLITIS	□	□
CHEST PAINS	□	□	HEART ATTACK/FAILURE	□	□	OSTEOPOROSIS	□	□	TUBERCULOSIS	□	□
COLD SORE/FEVER BLISTERS	□	□	HEART MURMUR	□	□	PAIN IN JAW JOINTS	□	□	TUMORS OR GROWTHS	□	□
CONG.HEART DISORDER	□	□	HEART PACEMAKER	□	□	PARATHYROID DISEASE	□	□	ULCERS	□	□
CONVULSIONS	□	□	HEART TROUBLE/DISEASE	□	□	PSYCHIATRIC CARE	□	□	VENEREAL DISEASE	□	□
									YELLOW JAUNDICE	□	□

HAS THE PATIENT EVER HAD OR HAS ANY SERIOUS ILLNESS OR CONDITIONS NOT LISTED ABOVE? □ YES □ NO

IF "YES", PLEASE LIST:

ADDITIONAL INFORMATION/COMMENTS:

TO THE BEST OF MY KNOWLEDGE, THE QUESTIONS ON THIS FORM HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY (OR THE PATIENT'S) HEALTH: IT IS MY RESPONSIBLITY TO INFORM THE DENTAL OFFICE OF ANY CHANGES IN MEDICAL STATUS.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN: **DATE:**