Palmer Werner
CONTEMPORARY DENTISTS

PATIENT INFORMATION

NAME: _____ SEX: **MALE** **FEMALE** DOB: ___/_____/_____
First MI Last

HOME #:_____CELL #: _____ WOULD YOU LIKE TEXT REMINDERS? **YES** **NO**

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

E-MAIL: _____ PHARMACY: _____

CHECK APPROPRIATE BOX: MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED

IF A MINOR, ARE THE PARENTS: MARRIED DIVORCED SEPARATED

IF PATIENT IS A STUDENT,

NAME OF SCHOOL/COLLEGE: _____CITY: _____STATE: _____

SPOUSE OR PARENT/GUARDIAN NAME: _____

PATIENT'S OR PARENT/GUARDIAN'S EMPLOYER: _____ WORK NUMBER: _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY:

_____PHONE NUMBER: _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT: _____DOB: _____/_____/_____

SSN: _____-_____-_____RELATIONSHIP TO PATIENT_____

ADDRESS: _____CITY: _____ STATE: _____ZIP CODE: _____

PHONE NUMBER: _____ E-MAIL: _____

EMPLOYER: _____ WORK PHONE: _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? **YES** **NO**

INSURANCE INFORMATION

NAME OF INSURED_____ RELATIONSHIP TO PATIENT: _____

DOB: _____/_____/_____ SSN: _____-_____-_____ DATE EMPLOYED: _____

NAME OF EMPLOYER: _____ WORK PHONE: _____

ADDRESS OF EMPLOYER: _____CITY: _____STATE: _____ ZIP CODE: _____

INSURANCE COMPANY: _____GROUP #: _____

INS.CO. ADDRESS_____CITY: _____STATE: _____ZIP CODE: _____

ID #: _____ (IF ONE IS GIVEN) INS.CO. PHONE#: _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? YES NO IF YES, COMPLETE THE FOLLOWING;

NAME OF INSURED_____ RELATIONSHIP TO PATIENT: _____

DOB: _____/_____/_____ SSN: _____-_____-_____ DATE EMPLOYED: _____

NAME OF EMPLOYER: _____ WORK PHONE: _____

ADDRESS OF EMPLOYER: _____CITY: _____STATE: _____ ZIP CODE: _____

INSURANCE COMPANY: _____GROUP #: _____

INS.CO. ADDRESS_____CITY: _____STATE: _____ZIP CODE: _____

ID #: _____ (IF ONE IS GIVEN) INS.CO. PHONE#: _____

DENTAL HISTORY

FORMER DENTIST: _____ CITY/STATE: _____

DATE OF LAST DENTAL VISIT: _____/_____/_____ DATE OF LAST DENTAL X-RAYS: _____/_____/_____

ARE YOU IN BRACES: YES NO WHO ARE YOU SEEING FOR ORTHO: _____

HOW OFTEN DO YOU FLOSS? _____

PLACE A MARK ON "YES" or "NO" TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING:

BAD BREATH	YES NO	BLEEDING GUMS	YES NO	BURNING SENSATION ON TONGUE	YES NO	JAW PAIN OR TIREDNESS	YES NO
CIGARETTE, PIPE , OR CIGAR SMOKING	YES NO	CLICKING OR POPPING JAW	YES NO	DRY MOUTH	YES NO	LOOSE TEETH OR BROKEN FILLINGS	YES NO
FINGERNAIL BITING	YES NO	GRINDING TEETH /CLENCHING	YES NO	GUMS SWOLLEN OR TENDER	YES NO	MOUTH BREATHING	YES NO
MOUTH PAIN, BRUSHING	YES NO	PAIN AROUND EAR	YES NO	PERIODONTAL TREATMENT	YES NO	SENSITIVITY TO COLD	YES NO
SENSITIVITY TO HEAT	YES NO	SENSITIVITY TO SWEETS	YES NO	SENSITIVITY WHEN BITING	YES NO	SORES OR GROWTHS IN YOUR MOUTH	YES NO

ARE THERE ANY ADDITIONAL QUESTIONS OR CONCERNS IN REFERENCE TO YOUR ORAL HEALTH?

_____

_____

MEDICAL HISTORY

PHYSICIAN'S NAME: _____DATE OF LAST VISIT: _____

HAVE YOU HAD ANY SERIOUS ILLNESSES OR OPERATIONS: YES NO **IF YES, PLEASE DESCRIBE**:

_____

HAVE YOU EVER BEEN TOLD YOU NEED TO PRE-MED? YES NO **IF YES, PLEASE EXPLAIN WHY:**

_____

(WOMEN) ARE YOU PREGNANT? YES NO DUE DATE: ____/_____/_____ NURSING? YES NO TAKING BIRTH CONTROL PILLS? YES NO

PLEASE CHECK IF YOU HAVE/HAD:

ALLERGIES, HAY FEVER,	YES NO	BLEEDING ABNORMALLY, WITH EXTRACTIONS OR SURGERY	YES NO	CONGENITAL HEART LESIONS	YES NO
SINUSITIS	YES NO	HEPATITIS TYPE _____	YES NO	MITRAL VALVE PROLAPSE	YES NO
EPILESPSY	YES NO	STROKE	YES NO	TUBERCULOSIS	YES NO
RHEUMATIC FEVER	YES NO	BLOOD DISEASE	YES NO	CORTISONE TREATMENTS	YES NO
ANEMIA	YES NO	SWOLLEN NECK GLANDS	YES NO	NERVOUS PROBLEMS	YES NO
FAINTING OR DIZZINESS	YES NO	SWOLLEN FEET OR ANKLES	YES NO	TUMOR OR GROWTH ON HEAD OR NECK	YES NO
SCARLET FEVER	YES NO	CANCER/ CHEMO/ RADIATION	YES NO	COUGH, PERSISTENT OR BLOODY	YES NO
ARTHRITIS, RHEUMATISM	YES NO	LOW BLOOD PRESSURE	YES NO	PACEMAKER	YES NO
SHORTNESS OF BREATH	YES NO	HIGH BLOOD PRESSURE	YES NO	DIABETES	YES NO
ARTIFICIAL JOINTS	YES NO	CHEMICAL DEPENDENCY	YES NO	PSYCHIATRIC CARE	YES NO
HEADACHES	YES NO	KIDNEY DISEASE	YES NO	ULCER	YES NO
SINUS TROUBLE	YES NO	THYROID PROBLEMS	YES NO	EMPHYSEMA	YES NO
ASTHMA	YES NO	CIRCULATORY PROBLEMS	YES NO	RESPIRATORY DISEASE	YES NO
HEART MURMUR	YES NO	LIVER DISEASE	YES NO	VENEREAL DISEASE	YES NO
SKIN RASH	YES NO	TONSILLITIS	YES NO	GLAUCOMA	YES NO
BACK PROBLEMS	YES NO				
HEART PROBLEMS	YES NO				
SPECIAL DIET	YES NO				

LIST ANY MEDICATIONS THAT YOU ARE TAKING:

_____

ALLERGIES:

ASPIRIN BARBITURATES (SLEEPING PILLS) CODEINE IODINE LATEX LOCAL ANESTHETIC PENICILLIN SULFA

OTHER_____