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General Dentistry
Patient Information

NOTE: THE INFORMATION ON THIS FORM IS NECESSARY FOR OUR RECORDS. IT IS CONSIDERED STRICTLY CONFIDENTIAL. PLEASE COMPLETE ALL PARTS.

- ❑ MISS
- ❑ MRS.
- ❑ MR.
- ❑ DR.____

LAST FIRST MIDDLE

ADDRESS____

STREET CITY STATE ZIP

PHONES – HOME_____________________________ BUSINESS____________________________

DATE OF BIRTH____ SEX__________________

MARITAL STATUS__________________ OCCUPATION____________________________________

SOCIAL SECURITY NUMBER__________________________EMAIL__________________________

PERSON RESPONSIBLE FOR THISACCOUNT____

YOUR PHYSICIAN____

WHO RECOMMENDED YOU TO OUR OFFICE?____

GENERAL DENTAL HISTORY

1. How long has it been since your last dental visit?________________________________
2. Are you having discomfort now?____
3. Are your teeth white enough?____
4. Are dissatisfied in any way with your teeth and their appearance?__________________________

____

5. What would you like for us to do?____
6. If you could change your smile, what would you change?______________________________
7. Do you feel you have bad breath (halitosis)?____________________________________

PERMIT FOR TREATMENT

This is to certify that I, the undersigned, consent to the performing of the dental and oral surgical procedures agreed to be necessary or advisable including the use of local anesthetic as indicated and will assume responsibility for fees associated with those procedures. I, also, agree to allow photography of my teeth if deemed necessary.

❑ Patient's (Parent's) signature____Date____________

Do you have dental insurance:_____Insured________________________________SS#__________________

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO PHILIP C. WILKINS, DMD OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

❑ Signed (Insured Person)____Date____________

MEDICAL HISTORY

UPDATE

Are you allergic to ANYTHING?	❑ YES	❑ NO________
(Drugs, dental anesthetics, penicillin, jewelry, etc.)		
Are you now under the care of a physician? Why?________________________________	❑ YES	❑ NO________
Are you now taking nay drugs or medicine? Why?________________________________	❑ YES	❑ NO________
Have you had any blood transfusion? Approximate Dates ________________________	❑ YES	❑ NO________
Have you ever taken cortisone or steroids?	❑ YES	❑ NO________
Do you get out of breath easily?	❑ YES	❑ NO________
Do your ankles often swell?	❑ YES	❑ NO________
Do you smoke?	❑ YES	❑ NO________
Females only: Are you pregnant? Date Due_________	❑ YES	❑ NO________

PLEASE CHECK

- ❑ Heart Trouble
- ❑ Rheumatic fever
- ❑ High Blood Pressure
- ❑ Diabetes
- ❑ Liver disease
- ❑ Epilepsy
- ❑ Asthma
- ❑ Strep throat
- ❑ Pneumonia
- ❑ Bleeding problem
- ❑ Arthritis
- ❑ Tuberculosis
- ❑ Venereal disease
- ❑ Cancer
- ❑ Thyroid disease
- ❑ Fainting spells
- ❑ X-ray therapy
- ❑ AIDS
- ❑ Stomach, intestinal trouble
- ❑ Stroke
- ❑ Circulatory problems
- ❑ Blood disease (sickle cell anemia, etc.)
- ❑ Eye, ear, nose, throat trouble
- ❑ Hepatitis
- ❑ Sinus trouble
- ❑ Kidney disease
- ❑ Severe headaches

Indicate any disease, condition, or problem not listed above that you think I should know about:

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____

MEDICATIONS:

PATIENTS SEEKING IMPLANTS

1. How long ago were your last teeth removed?____
2. How many teeth were removed at that time?____
3. (If appropriate) Are you having more trouble with your upper denture of you lower denture?___________________
4. (If appropriate) Are you interested in having a dental implant done primarily for looks, to chew better, or both?__________

   ____
5. Have you noticed any change in your facial muscles in the past five years, such as sagging cheeks or more hollow cheeks?

   ____
6. Do you feel that your chin and your nose are too close together when your teeth are together?___________________

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7. (If appropriate) How many sets of dentures have you had made since your teeth were removed?_________________
8. (If appropriate) Is the set of dentures that you are presently wearing the last set you had made? If not, why aren't you wearing the most recent set of dentures that you had made?____________________________________
9. (Women only) Are taking any hormone supplements now?_____________________________________
10. Do you smoke?__ Do you drink? __Weekends, daily, occasionally or not at all?
11. Date of you last medical examination by a physician.____________________________________