



Welcome

Date _____

Patient Information (CONFIDENTIAL)

SS # _____

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ Zip Code _____

E-Mail _____ Work Phone _____ Cell Phone _____

Check Appropriate Box: Minor Single Married Divorced Widowed Separated

Occupation _____ Spouse's Name _____

If Student, Name of School/College _____ City _____ Full Time Part Time

Parent or Guardian's Name _____

Whom May We Thank For Referring You? _____

Person to Contact in Case of Emergency? _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to patient _____

Is this person currently a patient in our office? Yes No

Preferred Method of Payment Cash/Check Credit Card

Insurance Information

Name of Insured _____ Relationship to patient _____

Birthdate _____ SS# _____ Work Phone _____

Name of Employer _____ Union or Local # _____

Insurance Company _____ Group # _____ ID # _____

Ins. Co. Address _____ City _____ State _____ Zip Code _____

DO YOU HAVE A SECONDARY INSURANCE? Yes No

Insurance Company _____ Group # _____ ID # _____

Ins. Co. Address _____ City _____ State _____ Zip Code _____

Patient Medical History

Physician _____ Phone # _____ Date of Last exam _____

	Yes	No		Yes	No		Yes	No
AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Fainting/Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis/Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valves	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis Type _____	<input type="checkbox"/>	<input type="checkbox"/>	Type _____		
Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Special Diet	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding abnormally with extraction or surgery	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Feet or Ankles	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Neck Glands	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Lesion	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Tumor or growth on head or neck	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone Treatments	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Problems	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Cough, persistent /bloody	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>			
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>			
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>			
			Respiratory Disease	<input type="checkbox"/>	<input type="checkbox"/>			

1. Do you use tobacco products? Yes No If yes, what and how often, how long. _____
2. Do you use antidepressants or sleeping pills? Yes No If yes, list name(s) _____
3. Are you on any blood thinners, including aspirin? Yes No If yes, what? _____
4. Do you snore? Yes No
5. Have you ever had sleep studies? Yes No
6. Do you have Sleep Apnea? Yes No Do you use a C-Pap? Yes No
7. Have you ever seen an ENT? (ear, nose, throat doctor) Yes No Name of Doctor _____
8. Have you seen a Chiropractor? Yes No Name of Chiropractor _____
9. Have you ever seen a Neurologist? Yes No Name of Doctor _____
10. Do you have massage therapy regularly? Yes No Where? _____
11. Do you have special needs? Yes No If yes, please explain _____
12. WOMEN: Are you pregnant? Yes No
If yes, when is your due date? _____
Taking birth control pills? Yes No
Are you taking hormones? Yes No

MEDICATIONS

List all medications you are currently taking, including non-prescription medicines, vitamins and herbs.

ALLERGIES

- | | |
|--------------------------------------|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Local Anesthetic |
| <input type="checkbox"/> Barbituates | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Latex | _____ |
| <input type="checkbox"/> None | _____ |

Pharmacy Name _____

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

Do you have a specific dental problem? Describe _____

	Yes	No		Yes	No
1. Do your gums bleed while brushing/flossing?	<input type="checkbox"/>	<input type="checkbox"/>	9. Do you have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are your teeth sensitive to hot, cold or liquids?	<input type="checkbox"/>	<input type="checkbox"/>	10. Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you feel pain in any of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you had difficult extractions in the past?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have any sores or lumps in or near your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you had prolonged bleeding after an extraction?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you had any head, neck or jaw injuries?	<input type="checkbox"/>	<input type="checkbox"/>	13. Do you have dentures or partials? If yes, date of placement _____	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you bite your lips or cheeks?	<input type="checkbox"/>	<input type="checkbox"/>	14. Are you happy with the appearance of your teeth/smile?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you had orthodontic treatment? Braces? Dentist's Name _____	<input type="checkbox"/>	<input type="checkbox"/>	15. Would you like whiter teeth?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever experienced any of the following problems in your jaw?					
Clicking or Popping	<input type="checkbox"/>	<input type="checkbox"/>			
Pain (joint, ear, side of face?)	<input type="checkbox"/>	<input type="checkbox"/>			
Difficulty in opening or closing?	<input type="checkbox"/>	<input type="checkbox"/>			
Difficulty in chewing?	<input type="checkbox"/>	<input type="checkbox"/>			

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I understand that Dr. Mary A. Walsh-Cole does not participate with any insurance companies and that reimbursements will come to me directly from the insurance company. Dr Mary A. Walsh-Cole may use my healthcare information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services on my behalf.

Signature of Patient/Parent or Guardian _____

Date _____

Relationship to Patient _____