WOODBINE DENTAL
CONFIDENTIAL PATIENT INFORMATION

Name: ____ Date __________
FIRST MI LAST

Mailing Address ____

Phone# ______________________________ E-Mail ______________________
HOME CELL

Birth Date __________ Age ____ Male ___ Female ___ Social Security # ______-____-______

Marital Status: ___Minor ___Single ___Married ___Divorced ___Widowed

Place of Employment & Address ____________________________________

Are you a Full Time College Student? ____ Yes _____ No

Name/Address School ____

Emergency Contact & Phone: ______________________________________

Spouse or Parent/Guardian Name __________________________ Phone: __________

Employer ________________________________ Work #: __________________

Has any member of your family been treated in our office? ______ Relationship __________

RESPONSIBLE PARTY

Person Responsible for Account: ________________________ Home Phone: __________

Social Security # ______-______-______ Date of Birth __________________

Relationship to Patient __________________ Is this a current patient? _____ Yes ____ No

Mailing Address ____

Employer ____________________________ Work Phone ____________________

DENTAL INSURANCE INFORMATION

Insurance Co. (Name & Address) ______________________________________

Name of Insured ____________________________ Relationship to Patient __________

Birth Date __________ Social Security# ______-______-_____ Date Employed __________

Name of Employer ____________________________________ Union & Local# __________

Work Phone __________________ Group# ____________________ ID# ______________

Dental Secondary Insurance Co. ______________________________________

Insurance Co. (Name & Address) ______________________________________

Name of Insured __________________________ Relationship to Patient ______________

Birth Date ____________ Social Security# _____-_____-_____ Date Employed __________

Name of Employer ____________________________________ Union & Local# __________

Work Phone ________________ Group# ____________________ ID# ______________

Patient's Signature X ______________________________ **Date** ________

Signature required by Parent or Guardian for Minor

WOODBINE DENTAL MEDICAL HISTORY

Physicians Name & Phone ____

Are you under a Doctors Care Now? _______ Females: Are you Pregnant?______ What Trimester_______

Specialist Name & Phone ____

Are you allergic to: ___Latex ___Penicillin ___Codeine ___Other Medications____________________

____

Have you been told you needed to take antibiotics before dental appointments (Pre-Med)? ______

Do you use tobacco products? ____Yes ____No Drug Addiction ______ Alcohol Addiction _____

Have you had any joint replacements? ______ If yes, date of Surgery______________
(if yes check one) ___Full ___Partial: _____Hip R L _____Knee R L ______Shoulder R L

Have you ever had Valve Replacement? _____Yes _____No If Yes, date of Surgery________________

Have you had a port placed? _____Yes _____No Have you ever had Endocarditis(Heart infection)?________

Please **CIRCLE** if you have or have had any of the following:

Mitral Valve Prolapse	Kidney Trouble	Lung Disease	Bariatric Surgery
Heart Murmur	Hemodialysis	Asthma	Lap Band Surgery
Heart Attack	Diabetes	Emphysema	Autism
Defibrillator	Hypoglycemia	Thyroid Disease	Mentally Disabled
Pacemaker	Liver Disease	Glaucoma	Physically Disabled
Heart or Valve Defect	Hepatitis A, B or C	HIV- AIDS	Cerebral Palsy
Stroke	Arthritis/ Gout	Cancer	Epilepsy/Seizures
High Cholesterol	Blood Disease	Chemo or Radiation	Depression
High Blood Pressure	Anemia	Acid Reflux	ADD/ADHD
Low Blood Pressure	Hemophilia	Ulcers	Psychiatric Care

Do you have any disease or condition not listed above? ______________________________

Please list any medications including over the counter & non-prescription. Note what it is for.

PATIENT'S SIGNATURE ________________________________ **DATE**__________

Signature required by parent or guardian for minor

DATE	HEALTH CHANGES	PATIENTS SIGNATURE	STAFF ID