

DENTISTRY at WESTLAND - PATIENT INFORMATION

Name: _____ Sex: M / F Married Single Child Date: ___/___/___
Last First MI

Address: _____
street city state zip code

Phone (home) _____ (work) _____ (Cell) _____

Preferred Appointment times Morning Afternoon Evening Anytime

Birth Date: / / Social Security # ___ - ___ - ___ Email Address _____

Employer Name: _____ Occupation: _____

How were you referred to this office? (check all that apply)

Dentistry at Westland Website *Direct Mail* *Newspaper Ad* *Insurance Provider Directory*

Friend _____ *Other* _____

Former Dentist: _____ I've changed dentists due to: _____

HEALTH INFORMATION - For the following questions, circle yes or no

1. Are you in good health?.....Yes No
2. Has there been any change in your health in the past year?.....Yes No
3. My last physical exam was on _____/_____/_____
4. Are you now under the care of a physician?.....Yes No
If so, for what condition? _____
5. The name and address of my physician is: _____

6. Have you had any serious illness, operation or hospitalization within the past 5 years?.....Yes No
7. Are you taking or have you ever taken Bisphosphonates for osteoporosis or chemotherapy for multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia or Zometa) ?Yes No
8. Are you taking any medicine(s) including diet pills, non-prescription, vitamins, homeopathic or natural remedies?.....Yes No
If so, please list: _____

Have you ever had any of the following? Please check those that apply:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitro Valve Prolapse | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Nervous Disorder | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis _____ | Due Date _____ | |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Radiation Therapy | Other: |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Rheumatism | |
| <input type="checkbox"/> Excess Bleeding | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Problem | |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Mental Disorder | <input type="checkbox"/> Stomach Problem | |

Do you smoke or chew Tobacco? _____

Past history of alcohol or chemical dependency? _____

Have you had any serious trouble associated with previous dental treatment?.....Yes No

If so, explain: _____

To The best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at my next appointment

Signature of patient, parent or guardian

Date

