

ERWIN DENTAL

Dr. Travis Wiles, D.D.S.

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PATIENT INFORMATION

Date _____

Patient _____

Address _____

City _____ State _____ Zip _____

Sex: M F Age _____ Birthdate _____

Single Married Widowed Separated Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS # _____

Occupation _____

Spouse's Employer _____

Name of responsible party for this account _____

Relationship to patient _____

Whom may we thank for referring you _____

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DENTAL INSURANCE

Name of responsible party for account _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Subscribers Name _____

Birthdate _____ SS# _____

Relationship to the Patient _____

Is Patient covered by additional insurance Yes No

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Erwin Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I hereby authorize Erwin Dental to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____

Relationship _____ Date _____

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PHONE NUMBERS

Home _____ Work _____ Ext. _____ Spouse's Work _____

Best time and place to reach you between 8:00 a.m. - 5:00 p.m. _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household)

Name _____ Relationship _____

Home Phone _____ Work Phone _____

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DENTAL HISTORY

Reason for today's visit _____

Former D.D.S. (Optional) _____

City/State/Phone _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "Yes" or "No" to indicate if you have or have had any of the following:

Bad breath Yes No

Bleeding gums Yes No

Blisters on lips or mouth Yes No

Burning sensation on tongue

Chew on one side of mouth

Tobacco products Describe _____

Clicking or popping jaw

Dry mouth

Fingernail biting

Food collection between the teeth

Grinding teeth

Gums swollen or tender

Jaw pain or tiredness

Lip or cheek biting

Yes No

Loose teeth or broken fillings

Mouth breathing

Orthodontic treatment

Pain around ear

Periodontal treatment

Sensitivity to cold

Sensitivity to heat

Sensitivity to sweets

Sensitivity when biting

Sores or growths in your mouth

How often do you floss _____

How often do you brush _____

Yes No

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HEALTH HISTORY

Physicians Name _____ Date of last visit _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

	Yes	No		Yes	No		Yes	No
AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis, Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Disease	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valves	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis Type _____	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding abnormally, with extractions or surgery	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Skin Rash Special Diet	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of Feet or Ankles	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Neck Glands	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Lesions	<input type="checkbox"/>	<input type="checkbox"/>	Latex	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone Treatments	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tumor growth on head or neck	<input type="checkbox"/>	<input type="checkbox"/>
Cough, persistent or bloody	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Problems	<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss, unexplained	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
			Women:					
			Are you pregnant	<input type="checkbox"/>	<input type="checkbox"/>			
			Due Date _____					
			Are you nursing	<input type="checkbox"/>	<input type="checkbox"/>			
			Birth Control Pills	<input type="checkbox"/>	<input type="checkbox"/>			
			Name _____					

MEDICATIONS

List medications you are currently taking:

Pharmacy Name _____

Phone _____

ALLERGIES

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Local Anesthetic
<input type="checkbox"/> Barbiturates (Sleeping pills)	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Iodine	<input type="checkbox"/> Other _____
<input type="checkbox"/> Latex	_____

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DENTAL WANTS AND NEEDS

Are you having any problems with functions (chewing, swallowing, speaking, etc.) Yes No

If yes, please describe the problem and how long it has been going on _____

Are there any problems or concerns with the appearance of your teeth? Yes No

If yes, please describe what you would like to see changes (color, shape, alignment, etc.) _____

Would you be interested in learning about all the cosmetic possibilities offered by our office? Yes No

Are you familiar with Bonded Dentistry? Yes No

Thank you for your attention in completing our new patient Registration and History form. We understand it's lengthiness but it is essential we obtain these facts in order that we may deliver complete and whole body care to our patients. We trust you will see it's importance when you witness our thoroughness in obtaining our dental records.

We ask that if you have had any x-rays within the last 12 months, please bring them, or a copy, on your initial visit. You may have these forwarded by your previous dentist if you wish to do so, otherwise we will obtain the necessary x-rays for our diagnostics on your initial visit.

Our office looks forward to meeting with you and taking care of all your dental needs or wants. Thank you,

Dr. Travis Wiles, D.D.S.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

The undersigned hereby authorizes Erwin Dental to take x-rays, study models, photographs or any diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of (name patient) _____ dental needs and wants. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with (name of patient) _____ and further authorize and consent that Doctor choose and employ such assistance as they deem fit.

Signature of Patient (or Parent or Guardian)

Date

Doctor