WELCOME TO DR. WALKER'S OFFICE

(This information is necessary for our files and your health and will be considered **CONFIDENTIAL**)

PATIENT INFORMATION

Date _____

Patient name _____ SS#_____
Address _____ Occupation _____
City _____ Patient employer/school _____
State _____Zip Code _____ Spouse's/Parent(s) Name(s) _____
Sex □ M □ F Age_____ Birthdate _____ Spouse's Employer _____
□ Minor □ Single □ Married □ Divorced □ Partnered Whom may we thank for referring you?_____

CONTACT INFORMATION

Primary Contact #: _____ Cell Home Work (Circle one) **TEXT opt in**: □ Yes □ No
E-mail _____ **Email opt in**: □ Yes □ No

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____ Primary contact #:_____

DENTAL INSURANCE

Subscriber's Name _____ Is Patient covered by Secondary Insurance □ Yes □ No
Relationship to Patient _____ Subscriber's Name _____
Birthdate _____ Member# _____ Relationship to Patient _____
Insurance Co_____ Birthdate _____Member #_____
Group # _____Phone # _____ Insurance Co _____
Group # _____Phone #_____

DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____	Would you describe your present dental health as good?	□ Yes □ No
City State _____	Do you think you have active decay or gum disease?	□ Yes □ No
Date of last dental visit _____	Do you feel nervous about having dental treatment?	□ Yes □ No
Date of last dental x-rays _____	Have you ever had a bad experience in a dental office?	□ Yes □ No
How often do you floss? _____	Do you want to keep your remaining teeth?	□ Yes □ No
How often do you brush? _____	Do you like your smile? Why?_____	□ Yes □ No
	Have you ever had orthodontic treatment?	□ Yes □ No

Please check "yes" or "no" to indicate if you have had any of the following:

Bad Breath	□ Yes □ No	Mouth breathing	□ Yes □ No
Bleeding gums	□ Yes □ No	Mouth pain	□ Yes □ No
Blisters on lips or in mouth	□ Yes □ No	Oral cancer (date_____)	□ Yes □ No
Loose teeth or broken fillings	□ Yes □ No	Pain or ringing in/around the ear	□ Yes □ No
Clicking or popping jaw (TMJ)	□ Yes □ No	Periodontal treatment	□ Yes □ No
Dry mouth	□ Yes □ No	Sensitivity to cold	□ Yes □ No
Food collection between the teeth	□ Yes □ No	Sensitivity to heat	□ Yes □ No
Grind or brux your teeth	□ Yes □ No	Sensitivity when biting	□ Yes □ No
Gums swollen or tender	□ Yes □ No	Sensitivity to sweets	□ Yes □ No
Jaw pain or tiredness	□ Yes □ No	Snoring	□ Yes □ No
Lip or cheek biting	□ Yes □ No		

MEDICAL HISTORY

Primary Care Physician: _____ Date of last visit_____

Please check "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Liver condition	☐ Yes ☐ No
Allergies (LIST BELOW)	☐ Yes ☐ No	Epilepsy/seizures	☐ Yes ☐ No	Lung/respiratory disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Excessive Thirst	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Frequent Cough	☐ Yes ☐ No	Psychiatric problems	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Frequent Headaches	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Ringing in the ears	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Heart Condition (list)	☐ Yes ☐ No	Scarlet/Rheumatic Fever	☐ Yes ☐ No
Bruise Easily	☐ Yes ☐ No	_____		Seizures	☐ Yes ☐ No
Cancer/chemotherapy	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Hepatitis Type_____	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Chest Pain	☐ Yes ☐ No	High/low Blood Pressure	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Tingling Hands	☐ Yes ☐ No
Cold Sores/Fever Blisters	☐ Yes ☐ No	Hypoglycemia	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Cortisone Treatments	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Kidney Condition	☐ Yes ☐ No	Vertigo	☐ Yes ☐ No

Women only: Are you Pregnant? ☐ Yes ☐ No

Have you ever been hospitalized or do you have any other health concerns not listed? ☐ Yes ☐ No If yes, please explain:

_____

Have you ever **smoked, vaped** or used **tobacco**? □ Yes □ No If yes, how long?_____

Quit date (if applicable):_____

ALLERGIES (PLEASE LIST):

_____

_____

_____

_____

MEDICATIONS:

Please list medications you are currently taking

_____

_____

_____

_____

_____ _____ _____

Reviewing Doctor Date B.P.

SIGNATURE and AUTHORIZATION

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I hereby authorize payment directly to Dr. Walker's office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize Dr. Walker's office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative Date

_____ _____

Please print the name of Patient, Parent, Guardian or Personal Rep. Relationship to Patient