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 _____ Employer/School Address _____

E-mail _____ _____

Sex ☐ M ☐ F Age_____ Birthdate _____ Spouse's/Parent(s) Name(s) _____

☐ Married ☐ Widowed ☐ Single ☐ Minor Spouse's Employer _____

☐ Separated ☐ Divorced ☐ Partnered Whom may we thank for referring you? _____

PHONE NUMBERS

Home (___) _____Work (___) _____ Ext _____ Cell (___) _____

Spouse's work (___) _____ Best time and place to reach you _____

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

Name _____ Relationship _____

Home (___) _____Work (___) _____ Ext _____ Cell (___) _____

DENTAL INSURANCE

Subscriber's Name _____ Is Patient covered by Secondary Insurance ☐ Yes ☐ No

Relationship to Patient _____ Subscriber's Name _____

Birthdate _____ SS# _____ Relationship to Patient _____

Insurance Co_____ Birthdate _____SS# _____

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 (tooth straightening)?	☐ 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 mouth	☐ Yes ☐ No	Oral cancer (date_____)	☐ Yes ☐ No
Chew on one side of the mouth	☐ 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	Sores or growths in mouth	☐ Yes ☐ No
Loose teeth or broken fillings	☐ Yes ☐ No		

MEDICAL HISTORY

Medical Dr's Name _____ Phone (___) _____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	_____		Sinus Trouble	☐ Yes ☐ No
Cancer/chemotherapy	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Hepatitis Type_____	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Chest Pain	☐ Yes ☐ No	High/low Blood Pressure	☐ Yes ☐ No	Tingling Hands	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Cold Sores/Fever Blisters	☐ Yes ☐ No	Hypoglycemia	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Cortisone Treatments	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Vertigo	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Kidney Condition	☐ 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 or used tobacco? □ Yes □ No If yes, how long?_____

ALLERGIES (PLEASE LIST):

_____

_____

_____

Reviewing Doctor

MEDICATIONS:

Please list medications you are currently taking

_____

_____

_____ _____

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

Medical Updates (for office use only)

VELSCOPE EXAM: _____ _____ _____ _____

Date Exceptions B.P. Reviewed By

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

VELSCOPE EXAM: _____ _____ _____ _____