Jeffery S. Webb, D.D.S.

General Dentistry

Patient Information

This information is necessary for our files
and will be considered CONFIDENTIAL

Patients Name: _____ Today's Date: _____
(Last) (First) (I prefer to be called)

E-mail Address: _____ Age: _____ Birth Date: _____

If Patient is a minor, give parent's or guardian's name: _____ Relationship: _____

Residence Address: _____ City: _____ Zip: _____

Patient is: Married ❑ Single ❑ Widowed ❑ Domestic Partner ❑ Minor ❑

Social Security #: _____ Res. Phone# ( ) _____ Cell: ( ) _____

Employed by: _____ Occupation _____

Business Address: _____ Bus. Phone ( ) _____

Spouse's Name: _____ Soc. Sec. # _____

Name of nearest relative not living with you: _____

Relationship: _____ Phone #: _____

How did you hear about us?

- ❑ Friend/Family - if yes, please let us know so we can thank them for the referral _____
- ❑ Internet - if yes, please let us know where (ie. Google, Yelp, webpage, etc.) _____
- ❑ 1-800-Dentist
- ❑ Other - (please describe) _____

FINANCIAL INFORMATION

Do You Have Dental Insurance? Yes No Do You Have A Second Plan? Yes No

Name Of Insurance _____ Name Of Insurance _____

Name Of Insured _____ Name Of Insured _____

Birth Date _____ SS # _____ Birth Date _____ SS # _____

DENTAL / ESTHETIC HISTORY

1. HAVE YOU EVER HAD ANY UNFAVORABLE REACTION FROM A LOCAL ANESTHETIC (NOVACAINE, ETC.)? ..... YES NO
2. HAVE YOU HAD ANY SERIOUS TROUBLE ASSOCIATED WITH ANY PREVIOUS DENTAL TREATMENT? ..... YES NO
   IF SO EXPLAIN _____
3. HOW LONG SINCE YOUR LAST DENTAL TREATMENT? _____
   Date of last dental exam _____ Date of last cleaning _____
   Name of last treating dentist _____
4. DOES DENTAL TREATMENT MAKE YOU NERVOUS? ..... YES NO
   IF YES CHECK ✔ SLIGHTLY MODERATELY EXTREMELY
   _____
5. WOULD YOU DESIRE TO BE PRE-SEDATED? ..... YES NO
6. ARE YOUR TEETH SENSITIVE TO HEAT, COLD, OR ANYTHING ELSE? YES NO
7. WHY HAVE YOU COME TO THE DENTIST TODAY? _____
8. DO YOU NOW OR HAVE YOU EVER EXPERIENCED PAIN/DISCOMFORT IN YOUR JAW JOINT TMJ/TMD)? ..... YES NO
9. DO YOU CLENCH AND/OR GRIND YOUR TEETH? ..... YES NO
10. DO YOU HAVE FREQUENT HEADACHES? ..... YES NO
11. HAVE YOU BEEN DIAGNOSED WITH SLEEP APNEA? ..... YES NO
12. DO YOU WEAR CPAP? ..... YES NO

VII. WOMEN ONLY

Yes No Are you or could you be pregnant?
If YES, how many months along is your pregnancy?_____

Yes No Are you nursing?

Yes No Are you taking birth control pills?

VIII. ALL PATIENTS

Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain: _____

Yes No Have you ever taken Fen-phen? If YES, when _____

Yes No **Is there any issue or condition that you would like to discuss with the dentist in private?**

CONSENT FOR TREATMENT

The above health history is complete and correct to the best of my knowledge and it is my responsibility to inform this office of any changes in my medical status. I authorize and give consent to perform dental services agreed between Doctor and Patient and/or Guardian to be necessary or advisable, including the use of local anesthesia and other medication as indicated. I agree that, regardless of insurance coverage, I am responsible for payment of services rendered and that, regardless of insurance coverage, I am responsible for payment of services rendered and that a finance charge of 1 ½% will be applied to accounts past sixty days.

_____ _____

Signature of Patient, Parent, or Guardian **Date**

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consult ation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature: _____ Date: _____

Physician's Name: _____ Phone Number: _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist,or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient (Parent or Guardian) **Date** **Signature of Dentist** **Date**

Doctor's Notes _____

CONFIDENTIAL HEALTH HISTORY

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes No Is your general health good?

   If NO, explain _____

2. Yes No Has there been a change in your health within the last year?

   If YES, explain _____

3. Yes No Have you gone to the hospital or emergency room or had a serious illness in the last three years?

   If YES, explain _____

4. Yes No Are you being treated by a physician now? If YES, explain _____

   Date of last medical exam? _____ Reason for exam _____

   Name of Physician _____ Physician's Phone # ( ) _____

5. Yes No Are you in pain now? If YES, please explain _____

II. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING WITHIN THE LAST THREE YEARS?

Chest Pain	❑ Yes ❑ No	Blood in stools	❑ Yes ❑ No	Frequent vomiting	❑ Yes ❑ No
Fainting spells	❑ Yes ❑ No	Diarrhea or constipation	❑ Yes ❑ No	Jaundice	❑ Yes ❑ No
Recent significant weight loss	❑ Yes ❑ No	Frequent urination	❑ Yes ❑ No	Dry mouth	❑ Yes ❑ No
Fever	❑ Yes ❑ No	Difficulty urinating	❑ Yes ❑ No	Excessive thirst	❑ Yes ❑ No
Night sweats	❑ Yes ❑ No	Ringing in ears	❑ Yes ❑ No	Difficulty swallowing	❑ Yes ❑ No
Persistent cough	❑ Yes ❑ No	Headaches	❑ Yes ❑ No	Swollen ankles	❑ Yes ❑ No
Coughing up blood	❑ Yes ❑ No	Dizziness	❑ Yes ❑ No	Joint pain or stiffness	❑ Yes ❑ No
Bleeding problems	❑ Yes ❑ No	Blurred vision	❑ Yes ❑ No	Shortness of breath	❑ Yes ❑ No
Blood in urine	❑ Yes ❑ No	Bruise easily	❑ Yes ❑ No	Sinus problems	❑ Yes ❑ No

III. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING?

Heart Disease	❑ Yes ❑ No	AIDS/HIV	❑ Yes ❑ No	Psychiatric care	❑ Yes ❑ No
Heart Attack	❑ Yes ❑ No	Surgeries	❑ Yes ❑ No	Osteoporosis	❑ Yes ❑ No
Artificial joint	❑ Yes ❑ No	Hospitalization	❑ Yes ❑ No	Thyroid disease	❑ Yes ❑ No
Stomach problems or ulcers	❑ Yes ❑ No	Diabetes	❑ Yes ❑ No	Asthma	❑ Yes ❑ No
Heart Defects	❑ Yes ❑ No	Tumors or cancer	❑ Yes ❑ No	Hepatitis	❑ Yes ❑ No
Heart Murmurs	❑ Yes ❑ No	Chemotherapy	❑ Yes ❑ No	Sexual transmitted disease	❑ Yes ❑ No
Rheumatic fever	❑ Yes ❑ No	Radiation	❑ Yes ❑ No	Herpes	❑ Yes ❑ No
Skin disease	❑ Yes ❑ No	Arthritis, rheumatism	❑ Yes ❑ No	Canker or cold sores	❑ Yes ❑ No
Hardening of arteries	❑ Yes ❑ No	Emphysema or other lung disease	❑ Yes ❑ No	Anemia	❑ Yes ❑ No
High blood pressure	❑ Yes ❑ No	Kidney or bladder disease	❑ Yes ❑ No	Liver disease	❑ Yes ❑ No
Seizures	❑ Yes ❑ No	Stroke	❑ Yes ❑ No	Eye disease	❑ Yes ❑ No
Cosmetic surgery	❑ Yes ❑ No	Eating disorders	❑ Yes ❑ No	Transplants	❑ Yes ❑ No
Tuberculosis	❑ Yes ❑ No	Family history of heart disease	❑ Yes ❑ No	Family history of diabetes	❑ Yes ❑ No
		Who? _____		Who? _____	

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING?

Aspirin	Valium	Tetracycline
Codeine	Penicillin	Vicodin
Local anesthetic (Novacaine or Xylocaine)	Latex	Food
Nitrous oxide	Erythromycin	Metal (Nickel)

Others: _____

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS?

Recreational Drugs	Tobacco in any form	Antibiotics
Over-the-courter medicines	Alcohol	Supplements
Weight loss medications	Bisphosphonate (Fosamax)	Aspirin

Other: Please list: _____

VI. IF YOU ARE TAKING ANY PRESCRIPTION MEDICATIONS, PLEASE LIST THEM BELOW.

_____

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_____