RICHARD E. WHEATFILL, D.D.S.

Please complete **both sides** of the following confidential information legibly:

Patient Information:

_____
Last Name *First Name* *Middle Name*

Birth date: ____/____/_____ Social Security Number: _____ Driver's License _____

Address:_____City:_____State:_____Zip:_____

Home Phone: (_____)_____ Cell: (_____)_____ E-mail: _____

If patient is a child- Parents' Names: _____

Patient's (Parent's) Employer: _____ Phone: (____)_____

Spouse's Name: _____ Spouse's SSN: _____-_____-_____
Last *First*

Spouse's Employer: _____ Phone: (____)_____

Whom may we thank for referring you to our office?

_____

Is another member of your family a patient in our office?

_____

Emergency Contact:

Name:_____ Phone: (____) _____

General Health: ☐ Excellent ☐ Fair ☐ Good ☐ Poor

Are you now under the care of a physician? Yes / No

Physician's Name: _____ Phone:(____)_____

Are you now taking any medication, drugs, or supplements?

Yes / No If yes, please list those drugs:

_____

_____

_____

_____

Primary Dental Insurance:

Insurance Co: _____

Phone: (_____) _____

Name of Subscriber: _____

ID #_____

DOB: _____/_____/_____

Subscriber's SSN:_____

Secondary Dental Insurance:

Insurance Co: _____

Phone: (_____) _____

Name of Subscriber: _____

ID #: _____

DOB: _____/_____/_____

Subscriber's SSN:_____

Have you been hospitalized, had a serious illness, or surgery? (Explain) _____

_____

Continue on Back

Health History:
Are you allergic to any of the following (*please check if yes*):

Date:_____

Blood Pressure:

____/_____ , _____/_____

Pulse: _____, _____

□ Penicillin □ Erythromycin □ Valium □ Local Anesthetic □ Codeine □ Tetracycline
□ Sulfa Drugs □ Nitrous Oxide □ Novocain □ Percodan □ Latex □ Aspirin
□ Metals

If you are allergic to any other medication or substance please list:
_____

Have you ever had any of the following (*please check if yes*):

□ Heart attack / Stroke □ Heart murmur □Tuberculosis □ Cancer □ Joint replacement:_____
□ Bleeding problems □ Fainting spells □ Pacemaker □ Jaundice □ Arthritis
□ High blood pressure □ Convulsions □ Kidney disease □ Asthma □ Artificial prosthesis:_____
□ Mitral valve prolapse □ Tumor or growth □ Glaucoma □ Ulcers □ HIV / AIDS
□ Rheumatic fever □ Venereal disease □ Diabetes □ Hepatitis □ Herpes
□ Other _____

Do you smoke? Yes / No If so, how often?_____ Women – are you pregnant? Yes/No If so, how far along?_____

Dental History:

1. Previous dentist: _____ Date of last full set series of dental X-Rays:_____
2. Reason for this visit: _____ Are you experiencing pain at this time? Yes/No
3. Have you ever had any of the following?:
    a. Orthodontic treatment / braces ..... □ Yes □ No
    b. Oral surgery/ extractions ..... □ Yes □ No
    c. Periodontal (gum) treatment..... □ Yes □ No
    d. Bite adjusted..... □ Yes □ No
    e. Bite plate/appliance ..... □ Yes □ No
4. Do you have any loose teeth?.....□Yes □ No
5. Does food become caught between your teeth?..... □Yes □ No
6. Do your gums bleed when you brush or floss?..... □Yes □No
7. Problems of the jaw (TMJ): have you ever experienced any of the following?
    a. Clicking of the jaw, difficulty in opening or closing? ..... □ Yes □No
    b. Pain in joint, ear, or side of face..... □Yes □No
8. Habits:
    a. Do you snore?..... □ Yes □ No
    b. Do you wake up tired and are tired during the day?..... □ Yes □ No
    c. Do you have high blood pressure? ..... □ Yes □ No
    d. Do you experience or have been observed to stop breathing during sleep?□ Yes □ No
    e. Do you fall asleep in meetings or social situations?..... □ Yes □ No
    f. Clench or grind your teeth while awake or asleep..... □ Yes □ No
    g. Mouth breathe while you are asleep or awake ....□ Yes □ No
9. Do you feel nervous about dental treatment?
    a. Have you ever had an unsettling experience in a dental office?..... □ Yes □ No
    b. If there is anything else about dental treatment that bothers you?..... □ Yes □ No
    c. *(if yes please explain)*..... □Yes □ No
10. Are you satisfied with appearance of your teeth? ..... □ Yes □ No

Consent: To the best of my knowledge, this medical and dental history information is correct. I acknowledge that I have received a copy of the **Dental Board of California Dental Materials Fact Sheet**. I consent and agree to be treated for my dental requirements by Dr. Wheatfill and the dental staff under his supervision. I understand that I am fully responsible for all charges regardless of insurance coverage.

_____ Date: _____

Signature of patient or responsible party

Reviewed by Doctor: _____ Date: _____