New Patient Demographic and Health History Information

Date: _____

Personal Information

Patient Name:_____ Preferred Name: _____
DOB: __-__-____ Email Address: _____
Address: _____
City, State, Zip Code: _____
Best Contact Phone Number: _____ Home Work Mobile
Alternate Phone Number: _____ Home Work Mobile

Emergency Contact

Name: _____ Phone Number: _____
Relationship to Patient: _____

Healthcare Power of Attorney/Guardianship

Is the patient legally able to make independent decisions regarding dental treatment? YES NO
If "NO" please list the person designated as Healthcare POA or Guardian and their relationship to the patient

Name: _____
Relationship to patient: _____
Phone Number: _____ Email: _____

Please provide a copy of the official Healthcare POA designation for the patient record
Note: if the POA or Guardian is unable to attend appointments a consent for treatment form will need to be completed yearly. This can be obtained from one of our business team members.

Employer and Insurance Information

Subscriber's Full Name: _____
Subscriber's DOB: _____ Subscriber's SSN: _____
Subscriber's Relationship to Patient: _____
Subscriber's Employer: _____
Dental Insurance Carrier: _____
Dental Insurance Group #: _____ Dental Insurance ID #: _____

By signing below, I give permission for Walsh Dental Group to release information regarding my treatment to my insurance company. I understand that only information regarding the treatment I receive, necessary for claim processing, will be released. I also understand that I have the right to request a particular date of service not be billed to my insurance company, and in doing so accept responsibility for payment in full at the time of service. I agree to pay any and all charges not covered by my dental insurance. I also agree to pay my copayment at the time services are rendered.

_____ _____
Patient/Guardian Signature Date

Dental History and Smile Evaluation

Whom may we thank for referring you? _____
What is the date of your last dental visit? _____
Name and Address of Last Dentist: _____
_____
_____

What is your main reason for coming in today? _____
_____
_____

Are you nervous about having dental treatment?	YES	NO
Have you ever had a bad experience with dental treatment?	YES	NO
Do your gums bleed when brushing and/or flossing?	YES	NO
Do you ever have pain/soreness in your jaw joint?	YES	NO
Are you aware if you grind or clench your teeth?	YES	NO
Do you wake with or develop headaches throughout the day?	YES	NO
Do you currently wear a night guard?	YES	NO
Do you have missing teeth you would like to replace?	YES	NO
Would you like for your teeth to be straighter?	YES	NO
Are you happy with the color of your teeth?	YES	NO
Do you like the shape of your teeth?	YES	NO
Are you happy with the appearance of your teeth?	YES	NO

Is there anything you would change about your smile that is not listed above? YES NO
Please Explain: _____
_____
_____
_____

Fluoride Review

Please check any of the following that apply to you:

- No fluoride in your drinking water (past or present)/drink filtered or bottled water
- Have a history of gum disease or gums that have receded
- Have multiple fillings and/or crowns
- Family history of decay/tooth loss
- Dry mouth
- Currently in orthodontic brackets
- Sensitivity to hot, cold and/or touch
- Use whitening products
- Limited hand dexterity
- Snack frequently or use gum or hard candy with sugar
- History of chemotherapy or radiation
- Teeth trap food or don't feel clean
- Sip on beverages (not water) throughout the day
- Floss less than once per day
- Visit the dental office irregularly

Did you know fluoride can help strengthen your teeth and prevent cavities? If you have checked any of the above circumstances you are a candidate for fluoride treatment. Please ask your doctor and hygienist how fluoride can improve your oral health.

Medical History

Have you been under the care of a doctor in the past two years? YES NO

If yes, please explain the reason for care:_____

Are you sensitive to any of the following? (please mark)

_____Penicillin _____Amoxicillin _____Clindamycin _____Sulfa Drugs _____Codeine _____Aspirin _____Latex

_____Acetaminophen/Tylenol _____Ibuprofen/Advil _____Articaine _____Lidocaine _____Marcaine _____Epinephrine

_____ Nitrous oxide (N2O) _____Other: _____

Have you ever had excessive bleeding after a dental or medical procedure that has required special treatment? YES NO

Do you use tobacco products or vape? YES NO

Type: _____ How often: _____

Do you ever have shortness of breath or chest pain when walking up one flight of stairs? YES NO

Do your ankles swell during the day? YES NO

Do you use a CPAP? YES NO

Have you ever had a joint replacement? YES NO

Which joint: _____ Year surgery was completed: _____

Do you require antibiotic pre-medication prior to dental treatment? YES NO

Do you have a history of taking or are you currently taking bisphosphonates (Ex: Fosamax, Boniva, Actonel)? YES NO

FEMALE PATIENTS ONLY

Are you currently taking birth control? YES NO

What form (oral, IUD, etc): _____

Are you currently pregnant? YES NO

If yes, what is your due date: _____

Please check any of the following conditions that apply to you, past or present

- o Acid reflux
- o ADD/ADHD
- o Alcoholism
- o Allergies (environmental/seasonal)
- o Alzheimer's Disease
- o Anemia
- o Anxiety
- o Artificial Heart Valve
- o Artificial Joint
- o Arthritis
- o Asthma
- o Atrial Fibrillation (A-Fib)
- o Autoimmune (general)
- o Bruise Easily
- o Cancer/Tumor
- o Chemotherapy
- o Chron's Disease
- o Cognitive Disability
- o Cold Sores/Fever Blisters
- o Colitis
- o Congenital Heart Defect
- o COPD
- o COVID-19
- o Cortisone Medication/Injection
- o Depression
- o Dementia
- o Diabetes I/II
- o Diverticulitis
- o Eating Disorder
- o Emphysema
- o Epilepsy/Seizures
- o Fainting/Dizzy Spells
- o Fibromyalgia
- o Glaucoma
- o Heart Attack/Failure
- o Heart Murmur
- o Heart surgery
- o Hemophilia
- o Hepatitis A/B/C
- o Herpes Simplex Virus I/II
- o High cholesterol
- o HIV/AIDS
- o Hypertension (high blood pressure)
- o Hyperthyroidism
- o Hypotension low blood pressure)
- o Hypothyroidism
- o Irritable Bowel Syndrome
- o Kidney Disease
- o Liver Disease
- o Lupus
- o Macular Degeneration
- o Mitral Valve Prolapse
- o Osteoporosis
- o Pacemaker
- o Parkinson's Disease
- o Psychological Disorder
- o Radiation Therapy
- o Recreational Drug Use
- o Rheumatic Fever
- o Shortness of Breath
- o Sickle Cell Disease or Trait
- o Sleep Apnea
- o Snoring
- o Stroke
- o Substance Dependency
- o Trigeminal Neuralgia
- o Tuberculosis (TB)
- o Ulcers
- o Vertigo

MEDICATIONS

Please include all prescriptions, over-the-counter (OTC) medications, and supplements. If necessary, please attach a list.

_____

_____

_____

_____

By signing below I confirm that the above medical information was completed to the best of my knowledge.

_____ _____

Patient/Guardian Signature Date

Appointment Agreement

Thank you for choosing Walsh Dental Group as your dental provider. We are thrilled to have you as part of our dental family! As part of that family, we make every effort to value your time and commit to reserving a time in our schedule that is dedicated specifically for you.

We understand that on occasion appointments need to be changed; in these instances we request a **48 hour notice** via phone call to 715-524-2581 or 715-526-3315 to reschedule your appointment. In the event that 2 appointments are missed with no prior notice in a consecutive 6 month period, we require a non-refundable pre-payment to schedule your appointment a third time.

Thank you in advance for respecting the time we have reserved for you and entrusting us with your dental care. We look forward to working with you!

By signing below I indicate that I have read and understand the above statements regarding Walsh Dental Group's appointment policy.

_____ _____

Patient/Guardian Signature Date