Medical History/ Contact/ Insurance Update 2015

Today's Date: _____

Name: _____
Last First M.I.

Preferred Name: _____

Address: _____
PO Box (if applicable)Physical Address Required

_____
City State Zip Code

Birthdate: _____

Wake Dental Wellness

Medical Physician's Name and Phone #

_____
Name

_____
Phone #

Date of Last Visit: _____

Primary Contact Information:

We Offer Text and Email Confirmation

Home: _____

Cell: _____

Email: _____

Circle Where You Prefer To Be Contacted: Home Cell Work Email

Have you had any of the following? Circle YES or NO

YES/NO Abnormal Bleeding	***YES/NO*** High Blood Pressure	***YES/NO*** Heart Pacemaker	***YES/NO*** HIV +/AIDS
YES/NO Diabetes	***YES/NO*** Difficulty Breathing	***YES/NO*** Asthma/Arthritis	***YES/NO*** Stroke
YES/NO Drug/Alcohol Abuse	***YES/NO*** Emphysema	***YES/NO*** Ulcers/Colitis	***YES/NO*** Broken Jaw
YES/NO Glaucoma	***YES/NO*** Sinus Problems	***YES/NO*** Kidney Disease	***DENTAL INFORMATION***
YES/NO Artificial Valves	***YES/NO*** Tuberculosis	***YES/NO*** Liver Disease	***YES/NO*** Implants
YES/NO Psychiatric Problems	***YES/NO*** Venereal Disease	***YES/NO*** Hepatitis A/B/C	***YES/NO*** Ortho
YES/NO Heart Attack	***YES/NO*** Epilepsy/Seizures	***YES/NO*** Smoke/Tobacco Use	***YES/NO*** Dry Mouth
YES/NO Fainting	***YES/NO*** Congenital Heart Defect		***YES/NO*** Periodontal Disease/Surgery
YES/NO Cancer/Chemotherapy Date _____		***YES/NO*** Heart Surgery	Date: _____

YES/NO Other Health Problems:_____

Any Recent Surgery? _____

Are you ALLERGIC to any of following? Circle YES or NO

YES/NO Aspirin ***YES/NO*** Codeine ***YES/NO*** Penicillin ***YES/NO*** Erythromycin ***YES/NO*** Tetracycline

YES/NO Latex ***YES/NO*** Dental Anesthetics ***YES/NO*** Metals ***YES/NO*** Other:

Please list OTHER DRUG ALLERGIES: _____

For Women:

Are you taking birth controls pills? ☐yes ☐no

Are you Pregnant? ☐yes ☐no Week# _____

Are you nursing? ☐yes ☐no

Please List All Medications You Are Currently Taking:

_____

Person Responsible For Account: (*if minor; parent who attends child today)*

Name:

_____
Last First M.I.

Address:

_____
PO Box (If Applicable) Physical Address Required

_____
City State Zip Code

Insurance Information:

Insured's Name: _____
Insured's Employer:_____
Employer Address:_____
Insured's BirthDate: _____/_____/_____ SS# _____/_____/_____
Insured's ID _____
Insurance Co. Name: _____
Insurance Address: _____
Complete address (PO Box or Physical, City, State, Zip Code)
Group # _____ Phone # (_____) _____

Basic Information About How Our Office Handles Insurance:

As a courtesy to our patients, our office will file all dental insurance claims and give assistance to make sure that your insurance pays to the maximum. We must have all pertinent insurance information.

Our office is not a NETWORK PROVIDER FOR ANY INSURANCE PLAN.

Any unpaid insurance balance over **45 days** becomes the patient responsibility. All co-payments are due **at Time of Service**. If you have any questions, please see Insurance Billing.

No Insurance? No Problem!

Ask about our Dental Health Club Plan!
Yearly Membership with Savings
No Maximums, No Deductible

I understand the information I have given today is correct to the best of my knowledge and it is my responsibility to inform this office of any changes in my medical status.

Signature _____ Date: _____