WENDY L. WELLS, D.M.D PC

http://www.wellsfamilydentistry.net/ wellsfamilydentistry2010@gmail.com
1840 1st Avenue • Sterling, IL 61081 (815)625-2532

Medical & Dental History Form

Patient Name: _____ * _____ * ____ _____
Last First MI Preferred Name

Would you consider yourself to be in fairly good health? ◯ Yes ◯ No

Within the past year, have there been any changes in your general health? ◯ Yes ◯ No

What is the date (or approximate date) of your last medical exam?

_____

_____

Your Primary Care Physician's name, address, & phone number:

_____

_____

Please mark any of the following to indicate Yes in response to the question:

☐ Have you ever had complications following dental treatment?
☐ Are you currently under the care of a physician due to a specific condition?
☐ Have you been hospitalized within the last 5 years due to a surgery or illness?
☐ Are you currently taking any prescription or non-prescription medications?
☐ Do you use tobacco (smoking, chewing or vape pen)?
☐ Do you require the use of corrective lenses (contacts or glasses)?
☐ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

If any of the previous questions are marked, please explain:

_____

_____

WOMEN ONLY: Are you pregnant? ◯ Yes ◯ No

If Yes, when is the due date? _____

Please indicate if you have experienced any of the following:

- ☐ Acid Reflux
- ☐ Alzheimers
- ☐ Arthritis
- ☐ Back Problems
- ☐ BK
- ☐ Cancer/Tumor
- ☐ Chronic Fatigue
- ☐ Cold Sores
- ☐ Dental Anxiety
- ☐ Dizziness/Fainting
- ☐ Emphysema
- ☐ Fibromyalgia
- ☐ Hay Fever
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Hypothyroid
- ☐ Kidney Disease
- ☐ Low Blood Pressure
- ☐ Migraines
- ☐ Neurologic Disorder
- ☐ Pacemaker
- ☐ PRE-MEDICATE
- ☐ Rheumatic Fever
- ☐ SEE NOTE
- ☐ Sleep Apnea
- ☐ Sulfa Drug Allergy
- ☐ Tobacco user
- ☐ Venereal Disease
- ☐ ADHD
- ☐ Amoxicillin Allergy
- ☐ Artificial Joints
- ☐ Bactrim Allergy
- ☐ Blood Disease
- ☐ Celiac disease
- ☐ Clenching/Grinding
- ☐ Contact Dermatitis
- ☐ Depression/Anxiety
- ☐ Drug/Alcohal abuse
- ☐ Epilepsy
- ☐ GI Problems
- ☐ Headaches
- ☐ Heart Problems
- ☐ High Cholesterol
- ☐ Jaundice
- ☐ Latex Allergy
- ☐ Macular Degeneration
- ☐ Mitral Valve Prolaps
- ☐ No Known Allergies
- ☐ Parkinsons
- ☐ Psoriasis
- ☐ Rheumatism
- ☐ Seizures
- ☐ Stent
- ☐ Surgical Operations
- ☐ Tuberculosis
- ☐ Xerostomia
- ☐ Allergy to Metals
- ☐ Anemia
- ☐ Aspirin
- ☐ Barretts Disease
- ☐ BLOOD THINNER
- ☐ Cerebral Palsy
- ☐ Clindamycin Allergy
- ☐ COPD
- ☐ Diabetes
- ☐ Easily Winded
- ☐ Erythromycin Allergy
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Hepatitis
- ☐ HIV+
- ☐ Joint Replacement
- ☐ Lichen Planus
- ☐ Meniere's Syndrome
- ☐ Mouth Sores/Blisters
- ☐ No Medical Condition
- ☐ Penicillin Allergy
- ☐ Radiation Treatment
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Stomach Problems
- ☐ Thyroid Disease
- ☐ Ulcerative Colitis
- ☐ Allergy-SEE NOTE
- ☐ Anxiety
- ☐ Asthma
- ☐ Bipolar
- ☐ Blood Transfusion
- ☐ Chemotherapy
- ☐ Codiene Allergy
- ☐ Crohn's Disease
- ☐ Diverticulosis
- ☐ Eczema
- ☐ Excessive Bleeding
- ☐ Growths
- ☐ Heart Disease
- ☐ Herpes
- ☐ HPV
- ☐ Keflex Allergy
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ NSAIDS Allergy
- ☐ Pitutary Adenoma
- ☐ Respiratory Problems
- ☐ Seasonal Allergies
- ☐ Sinus Problems
- ☐ Stroke
- ☐ TMJ disorder
- ☐ Ulcers

Do you have any other health issues or allergies?

_____

_____

_____

What is the reason for your dental visit today?

_____

_____

When was your last visit to the dentist (if to a different office)?

_____

_____

What was done on your last dental visit (if to a different office)?

Prior Dentist's name, address, & phone number:

How frequently do you brush your teeth?

◯ 3 (+) a day ◯ Twice a day ◯ Once a day ◯ Weekly ◯ Seldom

How frequently do you floss your teeth?

◯ 1 (+) a day ◯ 2 - 6 weekly ◯ 1 - 6 monthly ◯ Seldom ◯ Never

Please mark any of the following to indicate Yes in response to the question:

☐ Do your gums bleed when you brush or floss?

☐ Do your teeth experience sensitivity to cold or hot temperatures?

☐ Are any of your teeth currently causing you pain?

☐ Do you grind your teeth (either consciously or during sleep)?

☐ Are any of your teeth loose, or are you concerned about any teeth loosening?

☐ Do you currently have any dental implants, dentures, or partials?

If any of the previous questions are marked, please explain:

If you could change anything about your mouth, teeth, or smile, what would it be?

☐ ***To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.**

Authorization

☐ ***I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.**

☐ ***I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.**

☐ ***I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.**

☐ ***I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).**

Relationship to Patient:

Response Date: