Waterford
DENTAL GROUP

Patient Biographical Information			
First Name:	Middle Initial:	Last Name:	Nickname:
Date of Birth	Gender	Social Security #:	
Address:	City:	State:	Zip:
Main Phone:	Cell Phone/Additional Phone:	Email:	
Please list the names of any friends or family currently in the practice:			
List any sports, hobbies, or musical instruments played:			
Whom may we thank for referring you to our practice?			

Financial Party Information			
First Name:	Middle Initial:	Last Name:	
Address:	City:	State:	Zip:
Home Phone:	2nd/Cell Phone:	Email:	
Social Security #:	Employer:	Occupation:	
Length of Employment:	Work Phone:	Relationship to Patient:	

Insurance Information – Primary Coverage		
Subscriber's Name:	Subscriber's Date of Birth:	
Insurance Company Name:	Address:	
Social Security # or ID #:	Group Number:	
Employer:	Relationship to Patient:	

Insurance Information – Secondary Coverage		
Subscriber's Name:	Subscriber's Date of Birth	
Insurance Company Name:	Address:	
Social Security # or ID #:	Group Number:	
Employer:	Relationship to Patient:	

Dental History

***Please circle Yes or No if the pt currently has or has had any of the following:**

Name of Current Dentist:			Phone:		
Speech problems/therapy?	Yes	No	Brush teeth daily?	Yes	No
Grind or clench teeth?	Yes	No	Floss teeth daily?	Yes	No
Oral habits (thumb/finger habit, lip/nail biting)?	Yes	No	Fluoride treatments?	Yes	No

Injury to face, jaw, teeth, or mouth?	Yes	No	Mouth breathing?	Yes	No
Discomfort from teeth or gums?	Yes	No	Snores during sleep?	Yes	No
Pain, tenderness, or noise in either jaw?	Yes	No	Requires premedication?	Yes	No
Frequent headaches?	Yes	No	Any missing or extra permanent teeth?	Yes	No
Neck/shoulder pain?	Yes	No	Apprehensive about dental care?	Yes	No
Frequent sore throats?	Yes	No	Frequently chews gum?	Yes	No

If any of the above dental questions were answered "Yes," please explain:

Medical History

***Please circle Yes or No if the pt currently has or has had any of the following:**

Physician Name:	Date of last Physical:	Patient's Health:	
Address:	City:	State:	Zip:

List any medications currently being taken by the patient:

List any drug allergies or sensitivities that the patient may have;

Rheumatic Fever	Yes	No	Cancer	Yes	No
Tuberculosis/Lung Disease	Yes	No	Family History of Cancer	Yes	No
Pneumonia	Yes	No	Received Radiation Treatment	Yes	No
Liver Disease	Yes	No	Growth Problems	Yes	No
Kidney Disease	Yes	No	Endocrine Problems	Yes	No
Heart Attack/Stroke	Yes	No	Hormone Therapy	Yes	No
Heart Disease	Yes	No	Latex/Metal Allergy	Yes	No
Congenital Heart Defect	Yes	No	Nervous Disorders	Yes	No
Heart Murmur	Yes	No	Bone Disorders/Bone Loss	Yes	No
Hemophilia	Yes	No	Diabetes	Yes	No
Hypertension/High Blood Pressure	Yes	No	Seizures/Epilepsy	Yes	No
Prolonged Bleeding/Transfusion	Yes	No	Handicaps/Disabilities	Yes	No
Anemia	Yes	No	Asthma	Yes	No
HIV/AIDS	Yes	No	Arthritis	Yes	No
Hepatitis	Yes	No	Treated for Emotional Problems	Yes	No
Tonsils/Adenoids Removed	Yes	No	Ever Been Hospitalized	Yes	No

If any of the above medical questions were answered "Yes," please explain:

Patients Under 18

Height:	Weight:	School:	Grade:
Father/Guardian 1 Name:		Mother/Guardian 2 Name:	

Has patient begun puberty?	Yes	No
If patient is a girl, has menstruation begun?	Yes	No
If patient is a boy, has their voice changed or have facial hair?	Yes	No
Has the patient grown in the past year or shoe size changed recently?	Yes	No
Is patient interested in treatment?	Yes	No
Has either biological parent ever had orthodontic treatment?	Yes	No

I understand that the information provided is correct to the best of my knowledge. I understand that it is my responsibility to inform the office of any changes in the patient's health or medical status.

I authorize the dental staff to perform the necessary dental services my child/patient may need during diagnosis and treatment with my informed consent.

_____ _____

Signature of Patient of Guardian Date