# Wheaton Dental Center
# 11300 Veirs Mill Road
# Wheaton, Maryland 20906

Patient Name: _____ Today's Date: _____

_____

Address Apt# City State/Zip Code

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Marital Status: □Single □Married □Other Sex: □Female □Male

Social Security #:_____-_____-_____ Date of Birth: _____/_____/_____

Responsible Party: _____ Relationship to patient: _____

_____

Address Apt# City State/Zip Code

Social Security #:_____-_____-_____ _____

Name of Insurance Carrier

How did you hear about our office: _____

For the following questions, circle ***Yes*** or ***No***, whichever applies. Your answers are for our records only and will be considered confidential.

1. Are you in good health? Yes No
2. Have there been any changes in your health within the part year? Yes No
3. Are you under the care of a physician now? Yes No
4. Have you had any serious illness, operations, or been hospitalized in the past 5 years? Yes No
5. Are you taking any medicine(s) including non-prescription medicine? Yes No
   If so, which ones and for what reason? _____
6. Do you have or have had any of the following diseases or heart problems:
   a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease? Yes No
   b. Cardiovascular disease(heart trouble, heart attack, angina, coronary occlusion, high blood pressure, arteriosclerosis, stroke) Yes No
   c. Diabetes Yes No
   d. Hepatitis, jaundice, or liver disease Yes No
   e. Respiratory problems, emphysema, bronchitis, asthma etc Yes No
   f. Arthritis or painful, swollen joints Yes No
   g. Sexually transmitted diseases Yes No
   h. Problems of the Immune System Yes No
7. Have you had abnormal bleeding? Yes No
   a. Have you ever required blood transfusion? Yes No
8. Are you allergic or have you had a reaction to:
   a. Local anesthetics Yes No
   b. Penicillin or other antibiotics Yes No
   c. Aspirin Yes No
   d. Codeine or other narcotics Yes No
   e. Latex Yes No
9. Have you had any serious trouble with any previous dental treatment? Yes No
   If so, explain: _____
10. Do you have any disease, condition, or problem not listed above that you think we should know? Yes No
11. Are you pregnant? Yes No
12. Are you nursing? Yes No

With signing this form I give permission to the participating dentist to review my Medical History Form, and perform an examination, take all necessary x-rays, and complete all minor procedures as needed.

I further understand that individual reactions to the treatment can not be predicted, and if I experience any unanticipated reactions during or following any treatment, I agree to report them to the office as soon as possible.

I understand that the success of the recommended treatment depends upon my cooperation in keeping scheduled appointments, following home care instructions, and reporting to the office any changes in health status as soon as possible.

Insurance benefits are merely an estimate of coverage, and NOT a guarantee of payment. The person responsible for this account will be held liable for any and all remaining amounts the insurance company does not cover. If it becomes necessary to forward this account to a third party for collections, the responsible party is accountable for all fees incurred in the collection process in addition to the delinquent amount.

I certify that I have read and I understand what is above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or other staff member responsible for any errors or omissions that I may have in the completion of this form.

Responsible party's signature

Today's date

Thank you for filling out this form completely. The information you have provided will help us serve you more effectively and efficiently. If you have any questions at any time, please ask. We are always happy to help

……
……..

Dental management considerations:

Signature of Dentist

Today's date