PATIENT INFORMATION – HEALTH & DENTAL HISTORY

Dr. Stephen F. Wood
13410 NW Military Hwy. San Antonio, TX 78231

Name: _____ **Date of Birth:** _____

Preferred Name: _____ **SS#:**_____

Address: _____ **City:** _____ **St:**_____ **Zip:**_____

Phone: _____ **Cell:** _____ **Work:** _____ **Email:** _____

Status: ☐Child ☐Single ☐Married ☐Partnered ☐Divorced/Separated ☐Widowed **Dental Insurance:** ☐Yes ☐No

Occupation: _____ **Employer:** _____

Person Responsible for Account: _____

Dental Insurance Co.: _____ **Phone #:**_____

Policy Holder's Name: _____Date of Birth: _____

Employer: _____S.S#/Member ID#: _____

Whom may we Thank for referring you to our office? _____

Have there been any changes in your general health or in the condition of your mouth in the past year? ☐Yes ☐No

If so, please explain:_____

Physician's Name: _____ Phone #: _____ Last Physical Exam: _____

Do you have or have you had any of the following diseases, medical conditions or procedures?

- ☒Yes ☒No - Alcohol/Drug Abuse
- ☒Yes ☒No - Anemia
- ☒Yes ☒No - Artificial Bones/Joints
- ☒Yes ☒No - Artificial Valves
- ☒Yes ☒No - Arthritis/Rheumatism
- ☒Yes ☒No - Asthma
- ☒Yes ☒No - Back Problems
- ☒Yes ☒No - Bleeding Problems
- ☒Yes ☒No - Cancer/Tumors
- ☒Yes ☒No - Chemotherapy
- ☒Yes ☒No - Chest Pains
- ☒Yes ☒No - Congenital Heart Defect
- ☒Yes ☒No - Diabetes/Hypoglycemia
- ☒Yes ☒No - Difficulty Breathing
- ☒Yes ☒No - Emphysema
- ☒Yes ☒No - Epstein-Barr
- ☒Yes ☒No - Fainting/Seizures/Epilepsy
- ☒Yes ☒No - Frequent Neck Pain
- ☒Yes ☒No - Glaucoma
- ☒Yes ☒No - Head Injuries
- ☒Yes ☒No - Heart Attack/Stroke
- ☒Yes ☒No - Heart Disease
- ☒Yes ☒No - Heart Murmur
- ☒Yes ☒No - Heart Surg/Pacemaker
- ☒Yes ☒No - Hepatitis A – B – C
- ☒Yes ☒No - High/Low Blood Pressure
- ☒Yes ☒No - HIV+/AIDS/ARC
- ☒Yes ☒No - Jaw Problems TMJ/TMD
- ☒Yes ☒No - Kidney Problems
- ☒Yes ☒No - Liver Problems
- ☒Yes ☒No - Mitral Valve Prolapse
- ☒Yes ☒No - Multiple Sclerosis
- ☒Yes ☒No - Persistent Cough
- ☒Yes ☒No - Respiratory Problems
- ☒Yes ☒No - Rheumatic Fever
- ☒Yes ☒No - Scarlet Fever
- ☒Yes ☒No - Severe/Frequent Headaches
- ☒Yes ☒No - Shingles/Hive/Skin Rash
- ☒Yes ☒No - Sinus Problems
- ☐Yes ☐No - Stomach Problems/Ulcers
- ☐Yes ☐No - Thyroid Problems
- ☐Yes ☐No - Tuberculosis TB
- ☐Yes ☐No - Venereal Disease
- ☐Yes ☐No - Xray or Cobalt Treatment

Please list any other surgeries/medical conditions you have/had: _____

_____

Do any of the following apply to you?

Have you ever had abnormal bleeding associated with previous tooth extraction, surgery or trauma? ☐Yes ☐No

If so, please explain: _____

Have you ever had a Blood Transfusion? ☐Yes ☐No

If so, please explain: _____

Have you ever had surgery or radiation/x-ray treatment for a Tumor, Growth or Other Condition? ☐Yes ☐No

If so, please explain: _____

Have you ever had any serious Sinus Trouble associated with Dental Treatment? ☐Yes ☐No

If so, please explain: _____

Are you regularly in any situation which exposes you to Xrays or Ionizing Radiation? ☐Yes ☐No

Have you any other Disease or Condition that could affect your dental care or that we should know about? ☐Yes ☐No

Have you ever been diagnosed/treated for Sleep Apnea? ☐Yes ☐No If so, when? _____

Are you taking any of the following Drugs or Medicines? ☐ None

☐ Acetaminophen ☐ Antibiotics or Sulfa Drugs ☐ Anticoagulants ☐ Anti Depressants

☐ Aspirin ☐ Blood Pressure Medication ☐ Cortisone ☐ Digitalis or Heart Medicine

☐ Insulin or Similar Drug ☐ Nitroglycerin ☐ Sedatives ☐ Steroids

Any other medications you are taking? _____

_____

Have you ever taken: Bisphosphonates (ex: Aredia/Fosomax)? ☐ ☐Yes ☐No Phen-fen/Redux? ☐ ☐Yes ☐No

Are you allergic to or have you reacted adversely to any of the following?

☐ Acetaminophen ☐ Aspirin ☐ Codeine ☐ Dental Anesthetics ☐ Halcion ☐ Ibuprofen

☐ Iodine ☐ Latex ☐ Penicillin/Amoxicillin ☐ Sedatives ☐ Sulfa Drugs ☐ Tetracycline

☐ None ☐ Other:_____

Do you use tobacco? ☐Yes ☐No If so, how used? _____ How much? _____ How long? _____

Do you wear any of the following? *Contact Lenses:* ☐Yes ☐No *Pacemaker:* ☐Yes ☐No *Hearing Aid?* ☐Yes ☐No
Other: _____

For women: Are you on Birth Control? ☐Yes ☐No Are you nursing? ☐Yes ☐No
Are you Pregnant? ☐Yes ☐No If yes, how far along? _____

Please rate your general health from 1-10: _____ And your dental health from 1-10: _____

When was your last Dental Exam: _____ Any specific areas of your mouth that bother you? ☐Yes ☐No

Comments: _____

_____

_____

_____

I plan to take care of my financial responsibility by: ☐Cash ☐Check ☐Credit Card ☐Care Credit

*We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
* Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the financial manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interested charges and any other expenses incurred in collecting your account.
* Dental Insurance is a contract between you and your insurance carrier. It is the responsibility of the patient/guardian to be aware of their plan limitations and waiting periods. We will be happy to file your claim for you. We may provide you with an ESTIMATED co-payment amount at the time services are rendered, however, any unpaid amount by your insurance company will be your responsibility.
* If multiple occasions arise that you fail to give at least a 24-hour notice of cancellation for a scheduled appointment, there will be a fee of no less than $50.00 billed to your account.
* I authorize the staff to perform and necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
* I understand the above information and guarantee this form was completed and update correctly to the best of my knowledge and understand that it is my responsibility to inform this office of any changes to the information I have provided.

Signature of Patient/ Guardian **Date** **Provider Signature** **Date**

_____ _____ _____ _____