Dental Wellness of Lexington
Patient Information and Health History Form

Contact Information

Patient Name (First, Middle, Last) _____
Address _____
City _____ State _____ ZIP: _____
Home # (_____) _____-_____ Work # (if child, Parent's) (_____)_____-_____
Cell # (_____) _____-_____ Email Address_____
Patient Social Security # _____-_____-_____ Date of Birth _____ Age:_____
Marital Status Married _____ Single _____ Widowed _____

Employer (Name, Address): _____

Parent or Guardian (if child): _____ Phone# (_____) _____-_____
Parent Social Security #: _____-_____-_____

Spouse Name (First, Middle, Last): _____ Date of Birth: _____
Spouse Social Security # (for insurance purposes only): _____-_____-_____

In case of Emergency, please contact:
Name _____Relationship: _____ Phone # (_____)_____-_____

How would you like to be reminded of your appointments? (check all that apply)
_____ Text Cell #: (_____)_____-_____
_____ Email Email Address: _____

DENTAL Insurance Information

(Please provide our office with a copy of you insurance card)

Primary Insurance Company: _____ Phone #: ( )_____
Policy Holder Name: _____ Identification Number: _____
Policy Holder Date of Birth: _____ Group #: _____
Policy Holder Employer: _____

Secondary Insurance Company: _____ Phone #: ( )_____
Policy Holder Name: _____ Identification Number: _____
Policy Holder Date of Birth: _____ Group #: _____
Policy Holder Employer: _____

Who is Financially Responsible for this account? _____ Relationship: _____

How did you hear about our office? (Check all that apply)
Patient _____ Patient Name: _____
Doctor _____ Doctor Name: _____
TV ____ GiftCard ____ Internet ____ Yellow Pages ____ Radio ____ Brochure ____ Magazine ____
Other_____

Are you interested in receiving information about any of the services below? (Please check all that apply)

Bleaching (tooth whitening)	_____	Implants	_____
BOTOX/Juvaderm	_____	Porcelain Veneers/Lumineers	_____
Braces/Invisalign	_____	Sedation Dentistry	_____

Health History Page 2

Date of last **medical** exam: _____ What was this exam for? _____
Date of last **dental** exam: _____

Have you been hospitalized in the last 5 years? Yes _____ No _____
If yes, reason for hospitalization: _____

Are you currently receiving care? Yes _____ No _____
If yes, nature of care: _____

Please list the names/phone numbers of the physicians who are currently providing you care:

1.) _____ Phone #: _____
2.) _____ Phone #: _____
3.) _____ Phone #: _____

Do you have or have you ever had any of the following medical conditions? (Please check yes or no)

Migraines	Yes_____ No_____	Liver Disease (including Jaundice)	Yes_____ No_____
Epilepsy	Yes_____ No_____	Hepatitis, any form	Yes_____ No_____
Glaucoma	Yes_____ No_____	Type _____	
Thyroid	Yes_____ No_____	Sexually Transmitted Disease	Yes_____ No_____
Snoring or Sleep Apnea	Yes_____ No_____	HIV Positive/AIDS Related Complex	Yes_____ No_____
Do you use a CPAP?	Yes_____ No_____	Kidney Disease	Yes_____ No_____
Asthma	Yes_____ No_____	Previous Biopsies	Yes_____ No_____
Emphysema/Respiratory Illnesses	Yes_____ No_____	*Cancer	Yes_____ No_____
Heart Murmur	Yes_____ No_____	Type _____	Date_____
Abnormal Heart Condition	Yes_____ No_____	Anemia	Yes_____ No_____
Explain: _____		Abnormal bleeding from a cut	Yes_____ No_____
Abnormal Blood Pressure	Yes_____ No_____	Slow healing mouth sores	Yes_____ No_____
High/Low, What is it usually? S_____/D_____		Sore/Enlarged Lymph Nodes	Yes_____ No_____
Diabetes	Yes_____ No_____	Dry Mouth	Yes_____ No_____
HgA1C: _____ Date last checked:_____		Rheumatic Fever	Yes_____ No_____
Arthritis	Yes_____ No_____	Recurrent Illnesses	Yes_____ No_____
Joint Replacement	Yes_____ No_____	Explain:_____	
Area and date of replacement:_____		Other Infections:_____	

*Current or previous cancer patients:

a. Are you currently or have you been on (circle all that apply): Fosamax Fosamax plus D Actonel Boniva Prolia Zometa Aredia

b. If you answered yes: Duration of therapy: _____ Dose of medication:_____
If you are no longer on the medication, years since discontinuation: _____

c. Have you been treated with chemotherapy? Yes_____ No _____ Type of chemotherapy:_____

Do you have a medical condition that requires you to pre-medicate with antibiotics before dental treatment?
Yes_____ No_____ Reason: _____

Are you allergic to:

Penicillin	Yes_____ No_____	Codeine	Yes_____ No_____
Sulfa	Yes_____ No_____	Tylenol/Acetaminophen	Yes_____ No_____
Latex	Yes_____ No_____	Advil/Ibuprofen	Yes_____ No_____

Health History Page 3

Please list other allergies (include drugs/medications, foods, seasonal, etc):
_____

Are you allergic to or have you ever had any unusual reactions to local anesthetic? Yes_____ No_____
Explain: _____

Pharmacy Name: _____ Phone: _____

Please list any medications you are currently taking:

1.) _____ 6.) _____
2.) _____ 7.) _____
3.) _____ 8.) _____
4.) _____ 9.) _____
5.) _____ 10.) _____

Are you taking any Antacids? Yes ____ No ____
Are you taking Tagamet/Cimetidine? Yes ____ No ____ If yes, how often? _____
Are you taking any herbal supplements/medications? Yes _____ No _____
If yes, which ones? _____

Are you a smoker? Yes ____ No ____ If yes, how much per day? _____

Women: Are you pregnant? Yes ____ No ____
Are you planning a pregnancy in the next 6 months? Yes ____ No ____
Are you nursing? Yes ____ No ____

_____ _____ _____
Patient Name (Please print) Patient/Guardian Signature Date