DATE ______ / _____ / _______

PATIENT INFO & HEALTH HISTORY

FIRST NAME	MI	LAST NAME	PREFERRED NAME

HOME ADDRESS	CITY	ST	ZIP

HOME PHONE	WORK PHONE	CELL PHONE	EMAIL	OK TO TEXT Y / N OK TO EMAIL Y / N

D O B	SEX (CIRCLE) M / F	SSN	DRIVERS LICENSE / ID #	DL / ID Expiration

EMPLOYER	EMPLOYER ADDRESS / CITY / ST / ZIP	EMPLOYER PHONE

HOW DID YOU HEAR ABOUT OUR OFFICE

RESPONSIBLE PARTY IF SAME AS ABOVE, CHECK HERE ☐ & SKIP TO NEXT SECTION

FIRST NAME	MI	LAST NAME	DOB	SEX (CIRCLE) M / F	RELATION TO PATIENT

SSN	DRIVERS LICENSE / ID #	HOME PHONE	CELL PHONE

EMPLOYER	EMPLOYER PHONE	POSITION

EMPLOYER ADDRESS	CITY	ST	ZIP

MEDICAL CONTACTS

PREFERRED PHARMACY	PHARMACY LOCATION	PHARMACY PHONE
CURRENT PRIMARY CARE PHYSICIAN	DR. NAME	DR. PHONE

EMERGENCY CONTACT

FIRST NAME	LAST NAME	RELATION TO PATIENT
HOME PHONE	WORK PHONE	CELL PHONE

PRIMARY DENTAL INSURANCE IF NO DENTAL INSURANCE, TELL ME ABOUT THE IN-HOUSE DISCOUNT PLAN: ☐ YES ☐ NO

INSURED FIRST NAME / LAST NAME	DOB	SSN	EMPLOYER

PRI INS CO. NAME	INS PHONE	POLICY #	GROUP #

SECONDARY DENTAL INSURANCE

INSURED FIRST NAME / LAST NAME	DOB	SSN	EMPLOYER

PRI INS CO. NAME	INS PHONE	POLICY #	GROUP #

MEDICAL INSURANCE SOME PROCEDURES ARE BILLABLE TO MEDICAL, PLEASE PROVIDE:

INSURED FIRST NAME / LAST NAME	DOB	SSN	EMPLOYER

INS CO. NAME	INS PHONE	POLICY #	GROUP #

WESTMOORE DENTAL STUDIO

DATE ______ / _____ / _______

PATIENT INFO & HEALTH HISTORY

ARE YOU CURRENTLY UNDER A PHYSICIAN'S CARE? Y / N	PHYSICIAN NAME:	PHYSICIAN PHONE:	DATE OF LAST MEDICAL EXAM:
WOULD YOU CONSIDER YOURSELF TO BE IN: POOR / FAIR / GOOD / EXCELLENT HEALTH (circle one)	IN PAST 12 MONTHS, HAS THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH? Y / N	EXPLAIN IF YES:	
DO YOU HAVE A COUGH, SORE THROAT OR FEVER? Y / N	DO YOU USE TOBACCO (INCLUDING VAPE)? Y / N	DO YOU USE CONTROLLED SUBSTANCES? Y / N	DO YOU REQUIRE A PRE-MED FOR DENTAL APPOINTMENTS? Y / N

HAVE YOU EVER TAKEN FOSAMAX, BONIVA, ACTONEL OR ANY CANCER MEDICATION CONTAINING BISPHOSPHONATES? Y / N
IF SO, WHEN WAS YOUR LAST TREATMENT?

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING, INCLUDING NON-PRESCRIPTION AND HERBAL SUPPLEMENTS?

DO YOU SNORE OR BEEN TOLD THAT YOU SNORE? Y / N	HAVE YOU HAD A SLEEP STUDY OR TOLD TO GET ONE? Y / N	DO YOU WEAR A C-PAP OR BEEN TOLD TO? Y / N	HAVE YOU EVER HAD A SERIOUS HEAD OR NECK INJURY? Y / N

INDICATE IF YOU ARE ALLERGIC TO ANY OF THE FOLLOWING:

- ☐ ANESTHETIC (LOCAL) ☐ ASPIRIN ☐ CODEINE
- ☐ LATEX ☐ METAL ☐ PENICILLIN
- ☐ SULPHA ☐ OTHER:_______________________

WOMEN, PLEASE INDICATE IF YOU ARE:

- ☐ PREGNANT IF SO, HOW MANY WEEKS _____
- ☐ TAKING ORAL CONTRACEPTIVES ☐ NURSING

DO YOU CURRENTLY HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

☐ACID REFLUX	☐CHEST PAIN	☐HERPES	☐PSYCHIATRIC CARE	☐TUBERCULOSIS
☐ALCOHOL/DRUG ABUSE	☐DIABETES	☐HIGH CHOLESTEROL	☐RADIATION TREATMENT	☐TUMOR / GROWTH
☐ALLERGIES (SEASONAL)	☐DIZZINESS / FAINTING	☐HIV/AIDS	☐RESPIRATORY ISSUES	☐ULCER
☐ALZHEIMERS	☐EMPHYSEMA	☐HYPERTENSION (HBP)	☐RHEUMATIC FEVER	☐WHEELCHAIR ASSISTANCE
☐ANEMIA	☐CARRY EPINEPHRINE	☐HYPOTENSION (LBP)	☐RHEUMATISM	
☐ANGINA	☐EPILEPSY	☐HYPOGLYCEMIA	☐SEIZURES	
☐ART. HEART VALVE	☐EXCESSIVE BLEEDING	☐INSOMNIA	☐SHINGLES	
☐ARTHRITIS/GOUT	☐FIBROMYALGIA	☐IRREGULAR HEART RATE	☐SINUS PROBLEMS	
☐ARTIFICIAL JOINTS	☐FREQUENT HEADACHES	☐KIDNEY DISEASE	☐SLEEP APNEA	
☐ASTHMA	☐GLAUCOMA	☐LIVER DISEASE	☐STOMACH PROBLEMS	
☐ATRIAL FIBRILATION	☐HEART ATTACK	☐MITRO VALVE PROLAPSE	☐STROKE	
☐BLOOD DISEASE	☐HEART DISEASE	☐NERVOUS DISORDER	☐SWELLING LIMBS	
☐BLOOD THINNER	☐HEART MURMUR	☐OSTEOPOROSIS	☐THYROID DISEASE	
☐CANCER	☐HEMOPHILIA	☐PACEMAKER	☐TONSILITIS	
☐CHEMO / RADIATION	☐HEPATITIS	☐PAIN IN JAW / TMJ	☐TROUBLE SLEEPING	

NAME OF PREVIOUS DENTIST:_____________________________________ DATE OF LAST EXAM: _______________

WHAT IS THE MAIN REASON FOR YOUR DENTAL VISIT TODAY?____

ON A SCALE OF 1 (Poor) TO 10 (Excellent) HOW WOULD YOU RANK YOUR DENTAL HEALTH?___________________________

HOW FREQUENTLY DO YOU BRUSH YOUR TEETH? ____________ HOW FREQUENTLY DO YOU FLOSS YOUR TEETH? ______________

DO YOU LIKE YOUR SMILE?________IF NO, WHAT WOULD YOU CHANGE?____

DO YOU CURRENTLY HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

BLEEDING WHILE BRUSHING OR FLOSSING?	☐ Y	☐ N	JAW CLICKING, PAIN?	☐ Y	☐ N
SENSITIVITY TO HOT OR COLD LIQUIDS/FOOD?	☐ Y	☐ N	DIFFICULTY OPENING, CLOSING, CHEWING?	☐ Y	☐ N
SENSITIVITY TO SWEET OR SOUR LIQUIDS/FOOD?	☐ Y	☐ N	GUM PROBLEMS?	☐ Y	☐ N
TOOTH PAIN?	☐ Y	☐ N	DRY MOUTH?	☐ Y	☐ N
SORES OR LUMPS IN OR NEAR MOUTH?	☐ Y	☐ N	REMOVABLE PARTIALS?	☐ Y	☐ N
FREQUENT LIP OR CHEEK BITING?	☐ Y	☐ N	DENTURES?	☐ Y	☐ N
FREQUENT HEADACHES?	☐ Y	☐ N	DIFFICULT EXTRACTION?	☐ Y	☐ N
HEAD, NECK, OR JAW INJURY?	☐ Y	☐ N	ORTHODONTIC TREATMENT (BRACES)?	☐ Y	☐ N
CLENCHING OR GRINDING?	☐ Y	☐ N	HOME ORAL HYGIENE INSTRUCTIONS	☐ Y	☐ N