Walnut Ranch
DENTAL SPA

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us – we will be happy to help.

Date ______________

PATIENT INFORMATION *(CONFIDENTIAL)*

Patient's Sex ☐ F ☐ M

Name ____ Birth date ______________________

Address _______________________________ City_______________ State ______ Zip___________

Home Phone ________________ Cell Phone ________________ Work Phone __________________

Do you prefer to receive calls at your: ☐ Home ☐ Cell ☐ Work

SSN _________________________ Email ____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Other

Spouse or Parent/Guardian's Name ____

Person to contact in case of emergency ___________________________ Phone # _____________

Whom may we thank for referring you? ____

RESPONSIBLE PARTY

If different from before mentioned person

Name of Person responsible for this account ____

Address _______________________________ City _____________ State_____ Zip__________

Home Phone _________________ Cell Phone ________________ Work Phone ________________

Relationship to Patient _________________ Birth date______________ SSN __________________

Is this person currently a patient in our office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer.

☐ Cash ☐ Personal Check ☐ Credit Card/Visa/MC ☐ Care Credit Finance Plan

INSURANCE INFORMATION

Please provide a copy of your dental card and supply subscriber information below if you are covered as a dependent

Name of Insured ____

Relationship to Patient ______________ Birth date _______________ SSN_________________

Name of Employer _______________________________ Work Phone ___________________

Insurance Company ____

Ins. Address ____________________________ City _____________ State ____ Zip ________

Employee ID# ____________________ Group # ________________________

PATIENT MEDICAL HISTORY

Patient Name: ______________________

General Physician ____ Year of Last Exam___________

1. Are you under any regular medical treatment now?*(e.g. chemo, diabetes)*............... ☐Yes ☐ No
2. Have you had any previous surgeries, please list below .... ☐Yes ☐ No
   ____
3. Are you taking any medications including non-prescription medicine?.................... ☐Yes ☐ No
   *If yes, list medication(s) here or provide a list*_______ ________________________________
   ____
4. Have you ever taken Fen-Phen/Redux?.. ☐Yes ☐ No
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? (If yes circle one).................................. ☐Yes ☐ No
6. Do you use Tobacco? .... ☐Yes ☐ No
7. Do you use controlled substances? .... ☐Yes ☐ No
8. Are you wearing Contact Lenses?... ☐Yes ☐ No
9. Are you allergic to or have you had any reactions to the following?
   - Local Anesthetics *(e.g. Novocain)* .... ☐Yes ☐ No
   - Any Metals *(e.g. nickel, mercury, etc.)*... ☐Yes ☐ No
   - Latex Rubber... ☐Yes ☐ No
10. Are you allergic to or have you had any reactions to any Medications?.................... ☐Yes ☐ No
    If yes, please list. ____
11. **Women Only:**
    Are you pregnant or think you may be pregnant? .... ☐Yes ☐ No
12. Do you have or have you had any of the following:

High Blood Pressure	☐ *Yes*	☐ *No*	Heart Attack	☐ *Yes*	☐ *No*	Arthritis	☐ *Yes*	☐ *No*
Respiratory Problems	☐ *Yes*	☐ *No*	Cardiac Pacemaker	☐ *Yes*	☐ *No*	Tuberculosis	☐ *Yes*	☐ *No*
Rheumatic Fever	☐ *Yes*	☐ *No*	Fainting/Seizures	☐ *Yes*	☐ *No*	Stroke	☐ *Yes*	☐ *No*
Stomach Troubles	☐ *Yes*	☐ *No*	Kidney Disease	☐ *Yes*	☐ *No*	Anemia	☐ *Yes*	☐ *No*
Joint Replacement	☐ *Yes*	☐ *No*	Diabetes	☐ *Yes*	☐ *No*	Cancer	☐ *Yes*	☐ *No*
*Date of replacement*____________			Epilepsy/Convulsions	☐ *Yes*	☐ *No*	Liver Disease	☐ *Yes*	☐ *No*
Glaucoma	☐ *Yes*	☐ *No*	Aids/HIV Infection	☐ *Yes*	☐ *No*	Thyroid Problem	☐ *Yes*	☐ *No*
						Other ____________________		

PATIENT DENTAL HISTORY

Name of Previous Dentist and Location ____ Date of Last Exam ______________

1. Do your gums bleed while brushing or flossing? ☐ Yes☐ No
2. Are your teeth sensitive to hot or cold liquids/foods? ☐ Yes☐ No
3. Are your teeth sensitive to sweet or sour liquids/foods? ☐ Yes☐ No
4. Do you feel pain to any of your teeth? ☐ Yes☐ No
5. Do you have any sores or lumps in or near your mouth? ☐ Yes☐ No
6. Have you had any head, neck or jaw injuries? ☐ Yes☐ No
7. Have you ever experienced any of the following problems in your jaw?
   - a). Clicking ☐ Yes☐ No
   - b). Pain (joint, ear, side of face) ☐ Yes☐ No
   - c). Difficulty in opening, closing or chewing ☐ Yes☐ No
8. Do you have frequent headaches? ☐Yes ☐ No
9. Do you clench or grind your teeth? ☐ Yes☐ No
10. Do you bite your lips or cheeks frequently? ☐ Yes☐ No
11. Have you ever had any difficult extractions in the past? ☐ Yes☐ No
12. Have you ever had prolonged bleeding after extractions?☐ Yes☐ No
13. Have you had any orthodontic treatment? ☐ Yes☐ No
14. Do you wear dentures or partials? ☐ Yes☐ No
    If yes, date of placement ______________________
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? ☐ Yes☐ No
16. Do you like your smile? ☐ Yes☐ No

Authorization and Release

Payment is due in full at the time of treatment. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company. I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental service that I may need during diagnosis and treatment, with my informed consent.

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Signature of patient (or parent/guardian if minor) ***Date***