WASHINGTON SQUARE DENTAL GROUP
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PATIENT INFORMATION

Patient Name: _____ Preferred Name (if different)_____

Date of Birth:_____ Sex at Birth:_____ Gender: _____Pronouns: _____

SSN:_____ Marital Status: _____Married _____Single

Address:_____
Street Apt. #
_____
City State Zip

CONTACT INFORMATION

Cell: _____ Home: _____ Work: _____Ext:_____

Email: _____

Preferred method of contact: ☐ Cell ☐ Home ☐ Work ☐ Email

Pharmacy name:_____ Pharmacy Phone Number: _____

Pharmacy Address: _____

EMERGENCY CONTACT

Name: _____ Phone: _____ Relationship: _____

HOW DID YOU HEAR ABOUT OUR PRACTICE?

Friend/Family member's name:_____ Relationship:_____

Google ☐ Live/Work in neighborhood ☐ Referred by Dr. _____

EMPLOYMENT INFORMATION

Employer Name: _____ Occupation: _____

INSURANCE INFORMATION

Dental Insurance: _____

Subscriber Name: _____ Subscriber DOB: _____

Subscriber Address:_____

Subscriber SSN: _____Relationship to Patient:_____

ID Number: _____Group Number:_____

PLEASE PRINT NAME: _____ DATE:_____

GENERAL HEALTH HISTORY

PLEASE CHECK ANY THAT APPLY, EXPLAIN DETAILS BELOW:

- ☐ Heart Condition
- ☐ Artificial Heart Valve
- ☐ Pacemaker
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Diabetes
- ☐ Liver Problems
- ☐ Kidney Failure
- ☐ Fainting
- ☐ Bleeding Issues
- ☐ Anxiety / Mental Illness
- ☐ Cancer History (self)
- ☐ Chemotherapy/ Radiation
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ AIDS/HIV
- ☐ Rheumatic Fever
- ☐ Epilepsy
- ☐ Headaches / Migraines Other
- ☐ Sleep Apnea
- ☐ Osteoporosis
- ☐ Bisphosphate use

If any checked, please explain:_____

Daily Medications:_____

_____

Allergies:_____

Recent Surgery/joint replacements: _____

DENTAL HISTORY

Previous Dentist: _____ Phone: _____

Most Recent Exam: _____ Cleaning: _____ X-Rays: _____

What are your immediate dental concerns? _____

Would you like to discuss enhancing the appearance of your smile? Circle On ☐ Yes / ☐ No

Would you like to discuss options for teeth whitening? Circle One: ☐ Yes / ☐ No

Have you undergone prior orthodontic treatment? Circle One: ☐ Yes / ☐ No

Do you wear a sleep apnea device? Circle One ☐ Yes / ☐ No

Do you wear retainer ☐ Yes / ☐ No Do you wear a nightguard? : ☐ Yes / ☐ No

Check if you have had problems with any of the following:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ TMJ/ Jaw Pain
- ☐ Food Collection between teeth
- ☐ Broken Fillings
- ☐ Grinding/Clenching Teeth
- ☐ Loose Teeth
- ☐ Periodontal Treatment
- ☐ Sensitivity to Hot/Cold/Sweets
- ☐ Mouth Sores/Ulcers
- ☐ Dry Mouth

CONSENT

The above information is accurate and complete to the best of my knowledge. The undersigned hereby authorizes the Doctor to perform all the necessary procedures deemed appropriate for my dental needs.

Patient Signature (Guardian, if Minor) Date

Dentist Signature Date