WELLINGTON
Family Dentistry
Helping People Smile

Welcome to Our Office —Tell Us About Yourself

Name: _____ Preferred Name: _____

First MI Last

Address: _____ City _____ State _____ Zip _____

Email: _____ DOB: _____ SSN: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

How do you prefer for us to contact or confirm appointments? (circle one): Text Message Email Home Phone Cell Phone

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner

How did you hear about our office?

Insurance—Primary (**Please update if we have not already collected this information)**

Subscriber Name: Relationship to Patient: Subscriber DOB:

Subscriber Employer: Subscriber SSN / ID: Insurance Carrier:

Insurance Phone Number: Group Number:

Insurance—Secondary (**Please update if we have not already collected this information**)

Subscriber Name: Relationship to Patient: Subscriber DOB:

Subscriber Employer: Subscriber SSN / ID: Insurance Carrier:

Insurance Phone Number: Group Number:

Assignment and Release (sign only if Insured)

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Wellington Family Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____

Relationship: _____ Date: _____

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Dental History

Name: _____ Date: _____

How may we help you today? _____

Your current dental health is (circle one) Good Fair Poor

Do you require antibiotics before dental tx? Yes/No Reason _____

Are you currently in pain? Yes / No	Have you ever had gum or periodontal treatment? Yes / No
Do your gums bleed? Yes / No	Do you now or have you had any pain/discomfort in your jaw (TMJ) (TMD) Yes / No
Have you lost any teeth? Yes / No	Are you under any stress? i.e. (new job, moving, relationships) Yes / No
Do you like your smile? Yes / No	Is there anything you would like to change about your smile? Yes / No
Are you happy with the color of your teeth? Yes / No	Are you teeth sensitive to hot, cold or anything else? Yes / No
How many times do you Floss_____/week Brush_____/day	When was your last dental cleaning? When was your last dental visit?
Have you ever had a serious/difficult problem with any previous dental work? Yes / No	Have you ever had any unfavorable dental experience? Yes / No
How would you rate your level of dental anxiety? None High 0 2 4 6 8 10	How can we accommodate you during your dental visit?

Wellington Family Dentistry offers a wide variety of services to enhance and keep your smile beautiful.

Please circle any services below you would like our friendly staff to discuss with you during your visit.

Smile makeovers / Veneers	Extractions / Wisdom Teeth	Night / Sports Guard
Implants	Partials/Dentures	Teeth Whitening
Sedation	Crown/Bridge	Teeth Straightening / Invisible Braces

Nearest relative not living with you:

Name_____ Relationship_____

Address_____ Phone_____

I understand that the information I have provided 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.

Patient Signature_____ Date_____

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Name: _____

Date: _____

Medical History/Update

Height:_____Weight _____Age_____

Blood Pressure _____

Primary Physician's Name:
Physician's Phone:
Date of Last Visit:
Current Physical Health: Circle One Good Fair Poor
Are you currently under a physician's care? Please explain:

Do you use tobacco? Circle which applies Cigarettes Chew
Have you had any metal rods, pins, implants places? Where / when?
Are you required to pre-medicate prior to dental appts?
Have you had any surgical procedures? Yes No
List all medications or vitamins you are currently taking:

Conditions	Yes	No
Abnormal Bleeding		
Alcohol Abuse		
Anemia		
Angina Pectoris		
Arthritis		
Artificial Heart Valve		
Asthma		
Blood Transfusion		
Cancer		
Chemotherapy		
Claustrophobia		
Colitis		
Congenital Heart Defect		
Diabetes		
Difficulty Breathing		
Drug Abuse		
Emphysema		
Epilepsy		
Fainting Spells		
Fever Blisters		
Frequent Headaches		
Gag Reflex		
History Head Injury		

Conditions	Yes	No
Glaucoma		
HIV + AIDS		
Heart Attack		
Heart Murmur		
Heart Surgery		
Hemophilia		
Hepatitis (circle) A / B / C		
High Blood Pressure		
Joint Replacement		
Kidney Problems		
Liver Disease		
Low Blood Pressure		
Mitral Valve Prolapsed		
Osteoporosis/ take Bisphosphonates		
Pace Maker		
Psychiatric Problems		
Radiation Therapy		
Rheumatic Fever		
Seizures		
Sexually Transmitted Disease		
Shingles		
Sickle Cell Disease		
Persistent Cough/Swollen Glands		

Conditions	Yes	No
Sinus Problems		
Stroke		
Thyroid Problems		
Tuberculosis		
Ulcers		
Allergies	**Yes**	**No**
Aspirin		
Codeine		
Dental Anesthetics		
Erythromycin		
Jewelry		
Latex		
Metals		
Penicillin		
Sulfa		
Tetracycline		
Barbiturates/Sedatives		
Other:		
If Female, Please Answer	**Yes**	**No**
Are you taking Birth Control Pills?		
Are you pregnant? # of wks_____		
Are you nursing?		
Menopause		

Doctor's Comments:

Doctor's Signature: ***Date:***

Please Use This Page to List ANY Drugs/Pills/Medications or supplements that you are taking.

#	Name	Reason/Amount
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		