WOOSTER FAMILY DENTAL
(330) 264-8973

Wooster Family Dental
3431 Commerce Parkway Suite A
Wooster, OH 44691

Patient Information

Please take a moment to update your information as required by law every two years, thank you!

Patient Name: _____ Date: _____

SSN: _____ Gender: Male/Female - Family Status: Married Single Child Other

Date of Birth: _____ E-mail: _____

Phone: _____

Address: _____ City: _____ State: ____ Zip: _____

Employer: _____

Emergency Contact:

Name: _____ Phone: _____ Relationship: _____

Expectations

We respect our patients' time. Therefore we do everything we can do to work efficiently on treatment. We request the same from you. Please be on time and give us a **48 hour notice** if you need to adjust any appointment. All broken appointments will result in a $65.00 fee. ***Please initial:*** _____

Please initial here if you do not have Dental Insurance/Self-Pay Status: _____

Please provide a copy of your current Dental Insurance card

HIPAA Acknowledgement

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

May we phone, email, or send a text to you to confirm appointments? **YES / NO**

May we leave a message on your answering machine at home or on your cell phone? **YES / NO**

May we discuss your medical condition with any member of your family**?** **YES / NO**

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

If YES, please name the members allowed:

_____

Signature of Patient, Parent, or guardian (responsible party): _____ Date: _____

Health Information

1. Are you taking prescription(s)/over-the-counter or supplement drugs? **YES/NO** If yes, please list medications below:
   _____
2. Do you have any allergies? **YES/NO** If yes, please circle all that apply: Penicillin Antibiotics Anesthetics Aspirin Foods Latex Resins Other: _____
3. Do you require antibiotics before dental treatment? **YES/NO**

   If yes, what premedication (antibiotic) have you been prescribed & who is your prescriber? _____
4. **Women**: Are you pregnant? **YES/NO** Trying to get pregnant? **YES/NO** Are you taking oral contraceptives? **YES/NO**
5. **Symptoms or conditions below that you currently HAVE or HAVE HAD in the past year(s): (Please listed Year Diagnosed (DX))**

Alcohol Abuse: **Yes/No** Year Dx:_____ Rheumatic Fever: **Yes/No** Year Dx:_____ Allergies to Medicine(s) : **Yes/No** Year Dx:_____

Drug Abuse: **Yes/No** Year Dx:_____ Glaucoma: **Yes/No** Year Dx:_____ Sinus problems: **Yes/No** Year Dx:_____

Osteoarthritis: **Yes/No** Year Dx:_____ Hepatitis A, B, C: **Yes/No** Year Dx:_____ Thyroid Disease: **Yes/No** Year Dx:_____

Anemia: **Yes/No** Year Dx:_____ Shingles: **Yes/No** Year Dx:_____ Asthma: **Yes/No** Year Dx:_____

Liver Problems: **Yes/No** Year Dx:_____ Kidney Disease: **Yes/No** Year Dx:_____ AIDS/HIV: **Yes/No** Year Dx:_____

Tobacco Habit: **Yes/No** Year Dx:_____ Ulcers/Colitis: **Yes/No** Year Dx:_____ STDs: **Yes/No** Year Dx:_____

Psychiatric Care: **Yes/No** Year Dx:_____ Osteoporosis: **Yes/No** Year Dx:_____ Back Problems: **Yes/No** Year Dx:_____

Stroke: **Yes/No** Year Dx:_____ Rheumatoid Arthritis: **Yes/No** Year Dx:_____

Artificial Joints: **Yes/No** Year Dx:_____ Blood Pressure (High/Low): **Yes/No** Year Dx:_____

Tuberculosis: **Yes/No** Year Dx:_____ Diabetes (I/II/III): **Yes/No** Year Dx:_____

Heart Murmur: **Yes/No** Year Dx:_____ Epilepsy: **Yes/No** Year Dx:_____

Heart Ailments/Heart Attack: **Yes/No** Year Dx:_____

Mitral Valve Prolapse: **Yes/No** Year Dx:_____

6. Do you have any other health conditions? **YES/NO** If yes, please explain:
   _____
7. Are you currently taking bisphosphonate /Fosamax? **Yes/No**
8. Do you have history of cancer/chemotherapy/radiation? **YES /NO** Are you currently receiving treatment? **YES/NO**
9. If yes please specify: _____
10. Have you ever been a recipient of an organ transplant? **YES/NO**_____
11. Primary Care Physician _____Phone Number_____

VETERAN STATUS

Are you now or have you ever served in the military?

Yes No

Thank you!