WOODSTOCK SMILES
FAMILY & COSMETIC DENTISTRY

Patient Information: LegalName:______________________________PreferredName:________________________
Address:____City:______________State:_________Zip_______________
Phone (______)________________ Work Phone (_____) _______________ Cell Phone (______)__________________
Date of Birth:______________ Social Security Number:________________________
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Best method of contact: ☐ Home Phone ☐ Cell Phone ☐ Text messaging ☐ Email ☐ Postcard
Email Address____ How did you hear about us? ______________________

Responsible Party: Relationship to Patient: ☐ Self **(If self skip to Insurance information)** ☐ Spouse ☐ Parent ☐ Other
Name:____ Relationship to Patient: ______________________
Address:____
City:________________________________ State:__________ Zip:____________ Phone: (____)___________________
Employer________________________ Work Phone (____)_________________ SSN#_________________________

Insurance Information: Name of Insured:_______________________ DOB_____________SSN:________________
Employer:____________________________WorkPhone:(____)______________ Company_______________________
Group #____________________ID#________________________
Ins Co Address:____ Ins Co. Phone:_______________________

MEDICAL HISTORY:

1. Are you allergic to latex or to any medications? ____
2. Have you had any serious illness, operation, or hospitalization in the past? _____________________________________
3. Has there been a change in your health in the last 2 years? ____
4. Are you a "bleeder" or have you had excessive bleeding following dental treatment? ___________________________
5. Are you presently under the care of a physician? ____
6. Do you smoke or use tobacco products? ____
7. Do you take antibiotics before dental treatment? ____
8. Please list current medications____
9. **HAVE YOU HAD ANY OF THE FOLLOWING: Please Circle**

High Blood Pressure	**Heart Murmurs**	**Prolapsed Mitral Valve**	**Radiation/Chemo**
Heart Bypass	**Kidney Disease**	**Chemical Dependency**	**Hepatitis /Liver Disease**
Thyroid Disorders	**Joint Implants**	**Angina Heart Attack**	**Pacemaker**
Emphysema	**Tuberculosis**	**Stroke**	**Cancer**
Dialysis	**Breastfeeding**	**Asthma**	**Diabetes**

Currently Pregnant #of weeks______ **Aids or related Complex Blood disorders/HIV**

PATIENT SIGNATURE________________________________Date________________ **Please read & sign back.**