WOODHAVEN DENTAL
FAMILY | COSMETIC | EMERGENCY

WELCOME TO OUR OFFICE!

Today's date: ___ / ___ / ___

PATIENT INFORMATION

Name: ___ Birth Date: ___ Sex: ___ M ___ F
Address: ___ City: ___ State: ___ ZIP: ___
SS#: ___ Email: ___
Home phone #: ___ Cellphone #: ___
Employer: ___ Work phone #: ___
Spouse/Partner's Name: ___ Birth Date: ___ SSN# ___
Spouse/Partner's Employer: ___ Work phone #: ___
Who is responsible for this account? ___ Relation to patient: ___
In case of an emergency, please contact:
Name: ___ **Relation:** ___
Home phone #: ___ **Work/cell #:** ___

INSURANCE INFORMATION

Primary dental insurance company name: ___
ID #: ___ Group #: ___ Phone #: ___
Name of insured: ___ Relation to patient: ___
SS#: ___ Birth Date: ___ Employer: ___
Secondary dental insurance company name (if applicable): ___
ID #: ___ Group #: ___ Phone #: ___
Name of insured: ___ Relation to patient: ___
SS#: ___ Birth Date: ___ Employer: ___

DENTAL HISTORY

Reason for today's visit: ___
How did you find out about our office?: ___
Date of last dental visit: ___ Date of last dental x-rays: ___
Please only check (X) those that apply to you:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Blisters on lips/mouth
- ☐ Broken fillings
- ☐ Burning sensation lips/tongue
- ☐ Chewing on one side of mouth only
- ☐ Cigarette/cigar/pipe smoking
- ☐ Clenching or grinding teeth
- ☐ Clicking or popping of jaw
- ☐ Dry mouth
- ☐ Fingernail biting
- ☐ Food/floss stuck between teeth
- ☐ Gums swollen or tender
- ☐ Jaw pain/tiredness
- ☐ Lip/cheek biting
- ☐ Loose teeth
- ☐ Mouth breathing
- ☐ Prior orthodontic or periodontal treatment
- ☐ Sensitivity to cold/heat/sweets
- ☐ Sensitivity when biting
- ☐ Sores/growths in mouth

How often do you brush?: ___ How often do you floss? ___

HEALTH HISTORY

Primary care provider: ____ Date of last visit:_____________

Please check (X) those that apply to you:

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial heart valve
- ☐ Artificial joints
- ☐ Asthma
- ☐ Back problems
- ☐ Bleeding abnormally
- ☐ Blood disease
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Chemotherapy
- ☐ Celiac disease
- ☐ Congenital heart problems
- ☐ Crohn's disease, colitis
- ☐ Cough, persistent or bloody
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart murmur
- ☐ Heart problems
- ☐ Hepatitis: Type ___
- ☐ High blood pressure
- ☐ HIV
- ☐ Jaundice
- ☐ Jaw pain
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Low blood pressure
- ☐ Nerve problems
- ☐ Pacemaker
- ☐ Psychiatric care
- ☐ Radiation treatment
- ☐ Respiratory disease
- ☐ Shortness of breath
- ☐ Sinus trouble
- ☐ Skin rash
- ☐ Stroke
- ☐ Swelling of feet/ankles
- ☐ Swollen neck glands
- ☐ Thyroid problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor/growth of head/neck
- ☐ Ulcer
- ☐ Venereal disease
- ☐ Other: ____________________
- ☐ ____________________

Have you had COVID-19 _____yes _____no IF YES, when? ____________________________________

COVID vaccine date(s):_________________

Are you pregnant? ______yes ______no IF YES, due date:__________________________________

Are you nursing? _______yes ______no

MEDICATIONS

Please list or attach a copy of any medications you are currently taking:

____

____

Pharmacy:___________________________________City:_____________________Phone #:____________

ALLERGIES

Please list or attach a copy of any allergies that you have including food and environmental and symptoms:____

____

AUTHORIZATION AND RELEASE

The information on this form is accurate and complete to the best of my knowledge. I understand that it is my responsibility to inform the office if I ever have a change in health. Dr. Nguyen and/or her staff may use my health care information and may disclose such information to my insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature:____Date:___________________