WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

Wilsonville Dental Group

COMPASSION ◆ INTEGRITY ◆ EXCELLENCE

Terrence Clark, DMD Thomas Clark, DMD

About You

Today's Date:_____

E-mail Address:_____

❑ I prefer not to be contacted by e-mail
We will not share your e-mail with anyone

Name:_____
Last First MI Mr Mrs Ms Dr

Name I prefer to be called:_____

Parent or Legal Guardian Name (if minor):_____

Birthdate: ____/____/_____ Age:_____ ☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced

Home Address:_____
Street City State Zip

Mailing Address:_____
Street City State Zip

Home Phone: (_____)_____ Cell: (_____)_____ Work: (_____)_____ Ext. _____

Driver's License #:_____ Social Security #:_____

Whom may we thank for referring you?_____

Other family members seen by us: _____

Employer:_____ How long there?_____ Occupation:_____

Employer's Address: _____
Street/PO Box City State Zip

Spouse Information

Name:_____

Home Phone: (_____)_____ Cell: (_____)_____ Work: (_____)_____ Ext. _____

Emergency Contact Information

Name:_____ Relationship:_____

Home Phone: (_____)_____ Cell: (_____)_____ Work: (_____)_____ Ext. _____

Medical History

Physician's Name:_____

Address/Clinic:_____

Phone #: (_____)_____Date of last visit:_____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain:_____

_____

Do you use alcohol? ☐ Yes ☐ No

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you ever taken Fosomax or any other medication for bone preservation? ☐ Yes ☐ No

For Women: Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Unsure ☐ Yes ☐ No

Week # _____ Are you nursing? ☐ Yes ☐ No

Please check all conditions that you do have or have experienced in the past:

1. ☐ Heart Problems / Surgery
2. ☐ Low Blood Pressure
3. ☐ High Blood Pressure
4. ☐ Bleeding Disorder
5. ☐ Anemia
6. ☐ Endocarditis
7. ☐ Artificial Heart Valve
8. ☐ Congenital Heart Defects
9. ☐ Pacemaker
10. ☐ Asthma, Emphysema
11. ☐ Persistent Cough
12. ☐ Tuberculosis
13. ☐ Ulcers
14. ☐ Colitis or Irritable Bowel
15. ☐ Diabetes (I/II)
16. ☐ Liver Problems
17. ☐ Hepatitis (A,B, or C)
18. ☐ Kidney Problems
19. ☐ Stroke
20. ☐ Depression
21. ☐ Dizzy or Fainting Spells
22. ☐ Epilepsy/Seizures
23. ☐ Headaches
24. ☐ Anxiety
25. ☐ Psychiatric Problems
26. ☐ Artificial Bones/Joints
27. ☐ Cancer
28. ☐ HIV/AIDS
29. ☐ Sexually Transmitted Disease
30. ☐ Lupus
31. ☐ Arthritis
32. ☐ Drug Abuse
33. ☐ Glaucoma
34. ☐ Thyroid Problems

_____

_____

_____

Please list any serious medical condition(s) that you have experienced: _____

_____

_____

Please list all prescription/over the counter drugs, blood thinners or heart medications you are taking or have taken in the last 30 days:_____

_____

_____

_____

Are you allergic to any of the following? Please check all that apply:

☐ Aspirin	☐ Codeine	☐ Erythromycin	☐ Latex	☐ Sedatives	☐ Tetracycline
☐ Barbituates	☐ Dental Anesthetics	☐ Jewelry / Metals	☐ Penicillin	☐ Sulfa Drugs	☐ Other

Please list anything additional that causes allergic reactions: _____

_____

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status.

Patient Name: _____

_____ _____

Parent or Guardian Signature Date Patient Signature Date

Medical History Update

I have read my medical history dated _____ and confirmed that it states past and present medical condition

_____ _____

Signature Date

I have read my medical history dated _____ and confirmed that it states past and present medical condition

_____ _____

Signature Date

I have read my medical history dated _____ and confirmed that it states past and present medical condition

_____ _____

Signature Date

Dental History

Why have you come to the dentist today?_____

_____

Are you currently in pain? ☐ Yes ☐ No

Have you ever required antibiotics before dental treatment? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you floss daily? ☐ Yes ☐ No Brush daily? ☐ Yes ☐ No

Type of toothbrush? ☐ Manual ☐ Battery ☐ Electric ☐ Sonic

Are you satisfied with the appearance of your smile? ☐ Yes ☐ No

If No, what would you like to change: *(circle those that apply)*

Length of teeth, color, spaces, crowding, other: _____

_____

Have you ever had any serious complications with prior dental treatment? ☐ Yes ☐ No

If yes, what? _____

Have you had any head, neck or jaw injuries? ☐ Yes ☐ No

Do you have frequent headaches? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

Have you ever had periodontal disease? ☐ Yes ☐ No

Are your teeth sensitive to heat, cold, or anything else?_____

Do you have any loose teeth? ☐ Yes ☐ No

Previous / Present Dentist _____ Last Visit Date_____
(Please Circle)

Why did you leave your last dentist? _____

_____

Have you ever experienced any of the following problems in your jaw?

Clicking? ☐ Yes ☐ No

Pain (joint, ear, side of face)? ☐ Yes ☐ No

Difficulty in opening or closing? ☐ Yes ☐ No

Difficulty in chewing? ☐ Yes ☐ No

Do you clench or grind your teeth? ☐ Yes ☐ No

Have you had any orthodontic work (braces)? ☐ Yes ☐ No

Have you ever whitened your teeth? ☐ Yes ☐ No

If yes, what type of product?_____

COMFORT QUESTIONNAIRE

For each of these questions, circle the number under the word or phrase that best describes your feelings.	**Relaxed**	**A Little Uneasy**	**Tense**	**Anxious**	**Very Anxious**
If you had to go to the dentist tomorrow, how would you feel about it?	**1**	**2**	**3**	**4**	**5**
Imagine you are waiting in the dentist's office for your turn in the chair. How do you feel?	**1**	**2**	**3**	**4**	**5**
Imagine you are sitting in the dentist's chair as she prepares to give you a shot. How do you feel?	**1**	**2**	**3**	**4**	**5**
Imagine you are sitting in the dentist's chair as she prepares the drill to work on your teeth. How do you feel?	**1**	**2**	**3**	**4**	**5**
Imagine you are waiting in the hygienist's chair and he/she is getting the instruments used to scrape your teeth. How do you feel?	**1**	**2**	**3**	**4**	**5**

CONSENT

The undersigned hereby authorizes the doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with (name of patient) _____ and further authorize and consent that the doctor choose and employ such assistance as he deems fit. I understand that the use of anesthetic agents and certain treatments embody some risk. In good faith, the doctor will present these risks and alternatives to proposed treatment and my questions will have been answered in order to proceed in an informed fashion.

I hereby give my permission to Wilsonville Dental Group P.C. to release my dental records to my insurance company, specialists I may be referred to or others to whom I may request my records be sent.

I understand that responsibility for payment for dental services provided in the office for myself and/or my dependents is mine and not my insurance company, my employer or any other third party. Arrangements for payment will be made before initial treatment begins. Breach of this responsibility carries the penalty of compensating the doctor(s) for attorney's and collection fees. I understand that, where appropriate, credit bureau reports may be obtained.

I agree and understand that any and all legal disputes related to the services of Wilsonville Dental Group or affiliates shall be determined by submitting to binding arbitration.

Patient Name: _____ Date:_____

_____ _____

SIGNATURE OF PATIENT SIGNATURE OF PARENT OR GUARDIAN (RELATIONSHIP)