SHAWN WIDICK, D.D.S., INC.
704 Healdsburg Avenue, Suite A
Healdsburg CA 95448

Welcome!

Patient Information

Today's Date: _____ E-mail Address: _____ ☐ Yes ☐ No - I would like to receive correspondences via email

Name: _____ I prefer to be called: _____ ☐ Male ☐ Female
Last First Mi Mr Mrs Ms Dr

Birthdate: ___ /___ /_____ Age: _____ Social Security #: _____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Address: _____
Street City State Zip

Home Phone #: (_____) _____ Cell #: (_____) _____ Work Phone #: (_____)_____ Ext: _____ Driver's License #: _____

Where & when are best times to reach you? _____ Whom may we thank for referring you? _____

Other family members seen by us: _____

Responsible Party (if someone other than patient)

Name: _____ I prefer to be called: _____ ☐ Male ☐ Female
Last First Mi Mr Mrs Ms Dr

Birthdate: ___ /___ /_____ Age: _____ Social Security #: _____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Address: _____
Street City State Zip

Home Phone #: (_____) _____ Cell #: (_____) _____ Work Phone #: (_____)_____ Ext: _____ Driver's License #: _____

Spouse Information

His / Her Name: _____ Birthdate: __ /___ /___ Social Security #: _____

Employer: _____ Work Phone #: (____) _____ Ext: _____ Driver's License #: _____

Neighbor or Relative not living with you

His / Her Name: _____ Relation: _____ Work Phone #: (_____) _____ Home Phone #: (____) _____

Address: _____
Street City State Zip

Insurance

Primary Insurance Dental Coverage? ☐Yes ☐ No Relationship to Patient: ☐ self ☐ spouse ☐ child ☐ other _____

Name of Insured: _____ Insured's Birthdate: ___ /___ /___ Insured's Social or ID #: _____

Employer: _____
Phone #: _____
Address: _____
Address 2: _____
City, State, Zip: _____

Insurance Company: _____
Insured's ID #: _____
Phone #: _____
Address: _____
City, State, Zip: _____

Secondary Insurance Dental Coverage? ☐ Yes ☐ No Relationship to Patient: ☐ self ☐ spouse ☐ child ☐ other _____

Name of Insured: _____ Insured's Birthdate: ___ /___ /___ Insured's Social or ID #: _____

Employer: _____
Phone #: _____
Address: _____
Address 2: _____
City, State, Zip: _____

Insurance Company: _____
Insured's ID #: _____
Phone #: _____
Address: _____
City, State, Zip: _____

Dental History

Why have you come to the dentist today? _____

_____

Are you currently in pain? ❑ Yes ❑ No

Do you require 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 bristles on your toothbrush? ❑ Hard ❑ Medium ❑ Soft

Do your gums ever bleed? ❑ Yes ❑ No Ever Itch? ❑ Yes ❑ No

Have you ever had periodontal disease? ❑ Yes ❑ No

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

Do you clench **or** grind your teeth? ❑ Yes ❑ No

Do you still have wisdom teeth? ❑ Yes ❑ No

Previous / Present Dentist: _____ Last Visit Date: _____
(Please Circle)

Last full mouth X-rays series? When _____ ❑ Unsure

Are you happy with the way your smile looks? ❑ Yes ❑ No

If not, what would you change? _____

_____

Medical History

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name: _____

Address: _____
Street

_____
City State Zip

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 smoke or use tobacco in any other form? ❑ Yes ❑ No

Have you ever **taken** or are you **currently** taking a **Bisphosphonate**? ❑ Yes ❑ No

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

Are you pregnant? ❑ Unsure ❑ Yes ❑ No

Week #: _____ Are you nursing? ❑ Yes ❑ No

Do you or have you experienced the following?

Y N Abnormal Bleeding	Y N Colitis	Y N Hay Fever	Y N Liver Disease	Y N Shingles
Y N Alcohol Abuse	Y N Congenital Heart Defect	Y N Headaches	Y N Low Blood Pressure	Y N Sickle Cell Disease
Y N Anemia	Y N Diabetes	Y N Heart Attack	Y N Lupus	Y N Sinus Problems
Y N Arthritis	Y N Difficulty Breathing	Y N Heart Murmur	Y N Mitral Valve Prolapse	Y N Steroid Therapy
Y N Artificial Bones/Joints	Y N Drug Abuse	Y N Heart Surgery	Y N Pacemaker	Y N Stroke
Y N Artificial Valves	Y N Emphysema	Y N Hemophilia	Y N Persistent Cough	Y N Thyroid Problems
Y N Asthma	Y N Epilepsy	Y N Hepatitis A B C	Y N Psychiatric Problems	Y N Tonsillitis
Y N Blood Transfusion	Y N Ever Hospitalized	Y N Herpes	Y N Radiation Treatment	Y N Tuberculosis (TB)
Y N Cancer	Y N Fainting Spells	Y N High Blood Pressure	Y N Rheumatic Fever	Y N Ulcers
Y N Chemotherapy	Y N Fever Blisters	Y N HIV+/AIDS	Y N Scarlet Fever	Y N Venereal Disease
Y N Chicken Pox	Y N Glaucoma	Y N Kidney Problems	Y N Seizures	

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

Are you taking any prescription/over the counter drugs? ❑ Yes ❑ No If yes, please list each one: _____

_____

Are you allergic to any of the following?

Y N Aspirin	Y N Codeine	Y N Erythromycin	Y N Latex	Y N Sedatives	Y N Tetracycline
Y N Barbiturates	Y N Dental Anesthetics	Y N Jewelry / Metals	Y N Penicillin	Y N Sulfa Drugs	Y N 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 it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I assign the Doctor all insurance benefits. I understand I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover. Past due balances are subject to finance charges. I have received a copy of this offices Notice of Privacy Practices and the Dental Materials Fact Sheet.

_____
Signature Date