Union Bridge Family Dentistry

Dr. Yvette Wiesenmayer, D.D.S.
105 N Main St
P.O. Box 597
Union Bridge, MD 21791
(410) 775-7878

Welcome to Our Practice!

Today's Date: _____ E-mail Address: _____

Name: _____ 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

Mailing Address: _____
Street City State Zip

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

How did you hear about us? _____

Other family members seen by us: _____

Employer: _____ How long there? _____ Occupation: _____

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

Spouse or Emergency Contact Information

His / Her Name: _____ Birthdate: ___/___/___ Relationship: _____

Home Phone #: (_____)_____ Work Phone #: (_____)_____ Ext: _____

Insurance Information

Insurance Co. Name: _____ Phone #: (____)_____ Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Insured's Social Security #: _____

Insured's Address: _____
Street City State Zip

Insured's Birthdate: ___/___/___ Relationship: _____ Insured's Employer: _____

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 toothbrush? ❑ Manual ❑ Battery ❑ Electric

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 have any loose teeth? ❑ Yes ❑ No

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

Why did you leave your last dentist? _____

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Dental History (continued)

Are you satisfied with the appearance of your teeth? ❑ Yes ❑ No

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

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? ❑ Yes ❑ No

Have you ever whitened your teeth? ❑ Yes ❑ No
If yes, what type of product? _____

Medical History

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name: _____

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 Phen-Fen, Redux or Pondimin? ❑ 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	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, blood thinners or heart medications? ❑ 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 that 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 understand that I am responsible for payment of services rendered. As a courtesy, we will file your dental insurance as an out of network provider, so you may receive a reimbursement. I have received a copy of this office's Notice of Privacy Practices.

_____
Signature Date

office use only office use only office use only office use only **Medical History Update** *office use only office use only office use only office use*

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