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 medical\_history.pdf

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**PATIENT INFORMATION**

*Please Print*

Name \_\_\_\_\_

Social Security # \_\_\_\_\_

Home Address \_\_\_\_\_

Date of Birth \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Marital Status:  Single  Married  Other

Home E-mail \_\_\_\_\_

Do you have dental insurance?  Yes  No

Cellular # \_\_\_\_\_

**EMPLOYER INFORMATION**

Employer \_\_\_\_\_

Occupation \_\_\_\_\_

Employer's Address \_\_\_\_\_

Business Phone \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Business E-mail \_\_\_\_\_

**PARENT INFORMATION (if patient is a child)**

Name of Person Responsible For This Account \_\_\_\_\_

Social Security # \_\_\_\_\_

Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

City, State, Zip \_\_\_\_\_

**DENTAL PRIMARY INSURANCE**

Insurance Co. \_\_\_\_\_ Plan # \_\_\_\_\_

Insured Name \_\_\_\_\_

Insurance Address \_\_\_\_\_

Insured Birthdate \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Insured Soc. Sec. \_\_\_\_\_

Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer City, State, Zip \_\_\_\_\_

**DENTAL SECONDARY INSURANCE**

Insurance Co. \_\_\_\_\_ Plan # \_\_\_\_\_

Insured Name \_\_\_\_\_

Insurance Address \_\_\_\_\_

Insured Birthdate \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Insured Soc. Sec. \_\_\_\_\_

Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer City, State, Zip \_\_\_\_\_

## GENERAL INFORMATION

Appointment preference  Morning  Afternoon  No preference  Mon.  Tues.  Wed.  Thurs.  Fri.  Sat.

What is the best way to reach you?  Home phone  Work phone  Home email  Work email  Cellular

How did you hear about us? \_\_\_\_\_

## DENTAL INFORMATION

Reason for this visit \_\_\_\_\_

Do you require an antibiotic or pre-medication for a dental appointment  Yes  No

Are you happy with the appearance or color of your teeth  Yes  No

Do you have sensitivity to hot, cold or biting into foods  Yes  No

Do you clench or grind your teeth  Yes  No

Do you ever notice popping, clicking or pain in your jaw  Yes  No

Approx. date of last dental visit \_\_\_\_\_ Approx. date of last cleaning \_\_\_\_\_

Approx. date of last x-rays \_\_\_\_\_

Have you ever had an unusual reaction to a dental procedure or anesthetic  Yes  No

Have you ever had an unpleasant dental experience  Yes  No ( If yes, please explain) \_\_\_\_\_

## DENTAL HYGIENE INFO

How often do you brush your teeth  2 or more times per day  Once per day  Less than once per day

How often do you floss your teeth  daily  weekly  seldom  never

Have you noticed bleeding in your gums  Yes  No Ever noticed looseness in your teeth  Yes  No

Ever been told you have gum disease  Yes  No Have you ever had gum surgery  Yes  No

Do you smoke or use tobacco products  Yes  No

## MEDICAL HISTORY

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

Have you ever had any of the following:

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Artificial Joints              | <input type="checkbox"/> Rheumatic Fever        | <input type="checkbox"/> Herpes                                | <input type="checkbox"/> Excessive or prolonged bleeding |
| <input type="checkbox"/> Artificial/damaged heart valve | <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Diabetes                              | <input type="checkbox"/> Cancer (type _____)             |
| <input type="checkbox"/> Heart trouble/attack           | <input type="checkbox"/> Emphysema              | <input type="checkbox"/> Arthritis                             | <input type="checkbox"/> Thyroid condition               |
| <input type="checkbox"/> High Blood Pressure            | <input type="checkbox"/> H.I.V./A.I.D.S.        | <input type="checkbox"/> Sinus problems                        | <input type="checkbox"/> Other _____                     |
| <input type="checkbox"/> Heart murmur                   | <input type="checkbox"/> Tuberculosis           | <input type="checkbox"/> Mitral Valve Prolapse _____           |  |
| <input type="checkbox"/> Pacemaker                      | <input type="checkbox"/> Hepatitis (type _____) | <input type="checkbox"/> Health changes in the last year _____ |  |

Check any allergies that apply:  Penicillin  Sulfa  Aspirin  Anesthetic  Codeine  Nickel  Latex  Other \_\_\_\_\_

Are you pregnant or nursing?  Yes  No

List any medications you are now taking \_\_\_\_\_

Signature \_\_\_\_\_