SUSAN A. WIDICK, DDS, PC
general dentistry

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Revised 04/2015
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 Mobile # _____

Emergency Contact (name & phone) _____

EMPLOYER INFORMATION

Employer _____ Occupation _____

Business E-mail _____ Business Phone _____

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 # _____

Insurance Address _____ Insured Name _____

City, State, Zip _____ Insured Birthdate _____

Insurance Phone No. _____ Insured Soc. Sec. _____

Employer Name _____

DENTAL SECONDARY INSURANCE

Insurance Co. _____ Plan # _____

Insurance Address _____ Insured Name _____

City, State, Zip _____ Insured Birthdate _____

Insurance Phone No. _____ Insured Soc. Sec. _____

Employer Name _____

-- OVER PLEASE --

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:

❑ Artificial Joints
❑ Artificial/damaged heart valve
❑ Heart trouble/attack
❑ High Blood Pressure
❑ Heart murmur
❑ Pacemaker
❑ History of Bone Density drugs
❑ Rheumatic Fever
❑ Asthma
❑ Emphysema
❑ H.I.V./A.I.D.S.
❑ Tuberculosis
❑ Hepatitis (type ____)
❑ Herpes
❑ Diabetes
❑ Arthritis
❑ Sinus problems
❑ Mitral Valve Prolapse
❑ Health changes in the last year _____
❑ Excessive or prolonged bleeding
❑ Cancer (type _____)
❑ Thyroid condition
❑ Other _____
_____

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 _____