Wanlass Dental
Michael R Wanlass DDS

Welcome! Thank you for selecting our dental team! We strive to provide the best possible care - knowing that oral health affects total health. To get to know you better and meet your dental healthcare needs, please complete this form.

Patient Information *(confidential)*

Name_____

Street Address_____

City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____

Email Address_____ Birthdate_____

Preferred Pharmacy_____ Phone_____ Address_____

Check the Appropriate Box: ☐ Minor ☐ Single ☐ Divorced ☐ Widowed ☐ Married

Referred By_____

Patient's or Parent's Employer_____ Occupation_____ Work Phone_____

Can We Contact You at Work? ☐ Yes ☐ No

Spouse or Parent's Name_____

Employer_____ Occupation_____ Work Phone_____

Emergency Contact

Person to Contact in Case of Emergency_____Phone Number_____

Responsible Party

Name of Person Responsible for this Account_____Birthdate_____S.S.#_____

Street Address_____ City_____ State_____ Zip_____

Relationship to Patient_____ Home Phone_____

Employer_____ Occupation_____ Work Phone_____

Insurance Information

Name of Insured_____ Birthdate_____ S.S.#_____

Street Address_____ City_____ State_____ Zip_____

Relationship to Patient_____ Insurance Company_____

Do you have any additional insurance? ☐ Yes ☐ No If yes, complete the following information below:

Name of Insured_____ Birthdate_____ S.S.#_____

Street Address_____ City_____ State_____ Zip_____

Relationship to Patient_____

Employer_____ Occupation_____ Work Phone_____

Insurance Company_____ Group #_____ Policy/ID#_____

[over]

Medical History

Patient Name _____

Current and past health problems and medications could affect your dental treatment, completely answer the following questions.

Are you under a physician's care now? ☐ Yes ☐ No If yes, for what? _____

Name of Doctor _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, when? _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, when? _____

Are you taking any medications, prescriptions, or over-the-counter pills or supplements? ☐ Yes ☐ No

If yes, what? _____

Have you ever been diagnosed for depression? ☐ Yes ☐ No If yes, when? _____

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No If yes, for how long? _____

Are you on a special diet? ☐ Yes ☐ No Do you use tobacco? ☐ Yes ☐ No

Do you use a marijuana or any form of vaping? ☐ Yes ☐ No Do you have a hearing problem? ☐ Yes ☐ No

WOMEN: Are you ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking contraceptives?

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other _____

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING?

☐ AIDS/HIV Positive	☐ Chemotherapy	☐ Fatigue	☐ Hypoglycemia	☐ Rheumatism
☐ Alzheimer's Disease	☐ Chest Pains	☐ Frequent Cough	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Anaphylaxis	☐ Cold Sores/Fever Blisters	☐ Frequent Diarrhea	☐ Kidney Problems	☐ Shingles
☐ Anemia	☐ Congenital Heart Disorder	☐ Frequent Headaches	☐ Leukemia	☐ Sickle Cell Disease
☐ Angina	☐ Cortisone Medicine	☐ Genital Herpes	☐ Liver Disease	☐ Sinus Trouble
☐ Arthritis/Gout	☐ Diabetes	☐ Glaucoma	☐ Low Blood Pressure	☐ Sleep Apnea
☐ Artificial Heart Valve	☐ Human Papillomavirus	☐ Hay Fever	☐ Lung Disease	☐ Stomach Disease
☐ Artificial Joint*	☐ Drug Addiction	☐ Heart Attack/Failure	☐ Mitral Valve Prolapse*	☐ Stroke
☐ Asthma	☐ Easily Winded	☐ Heart Murmur*	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Auto Immune Disorder	☐ Eating Disorder	☐ Heart Trouble/Disease	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Emphysema	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Epilepsy or Seizures	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Special Needs
☐ Breathing Problem	☐ Prolonged Bleeding	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Excessive Thirst	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers or Acid Reflux
☐ Cancer	☐ Fainting Spells/Dizziness	☐ Hives or Rash	☐ Rheumatic Fever*	☐ Venereal Disease

*It is my responsibility to inform the dental office of any medication I am taking or of any changes in my medical status.

Have you ever had a serious illness not listed above? ☐ Yes ☐ No If yes, what? _____

Comments _____

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Authorization and Release

I certify that I have read, understand , and accurately answered the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my or my dependent's behalf. I agree to pay fees associated with any overdue balance sent to a collections agency. I also give my consent to dental treatment.

X _____

Signature of Patient, Parent, or Guardian Date