Patient Information Form

About You
Name: ____
Address: ____________________ City: ____________ Zip: ________
Phone: ____________________ Email: ____________________
Social Security Number: ______________ Date of Birth: __________ Age: ______
Employer: ____________________ Occupation: ____________________

Spouse or Significant Other
Name: ____
Employer: ____________________ Occupation: ____________________

Emergency Contact
Name: ____
Phone: ____________________ Relationship: ____________________
Address: ____________________ City: ____________ Zip: ________

Physician
Name: ____
Address: ____________________ City: ____________ Zip: ________
Phone: ____________________

Financial Information
Person responsible for payment: ______________________________
Relationship: ____________________

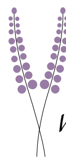
Insured Person's Name: ______________________________
Relationship: ____________________
Social Security Number: ______________ Date of Birth: __________ Age: ______
Insurance Company: ______________________________
Group: ____________________ Plan: ____________________

Previous Dentist
Name: ____
Address: ____________________ City: ____________ Zip: ________
Phone: ____________________

Reason for Changing Dentist: ______________________________

Dental History
How many years since your last check up and dental cleaning? ______________
How many years since your last full mouth X-rays? ______________
Have you experienced difficulty with previous dental treatment? ______________
If yes, please explain: ______________________________

How would you describe your dental anxiety? (1 = none, 10 = extreme) ______________
Would you like us to discuss anti-anxiety options prior to treatment? ______________



Wyatt Family Dental Care
Cherylin H. Wyatt, DDS

Health History

Please describe your overall health (1 = poor, 10 = excellent) ____________________________

Medication
Current medications & dosages: ____
____

Allergies to medications, i.e. Penicillin, Tetracycline, Sulfa, Aspirin, Codine, Latex: ____________
List other allergies ____

Have you ever been told that you need pre-medication antibiotics prior to treatment? ________
Have you ever taken bone loss prevention drugs like Fosamax or Boniva? _________________

Do you take recreational drugs, i.e. cannabis, cocaine, etc.? ______________________________
Do you smoke or vape? ________ How often? ____

Hospitalization, Trauma, or Surgeries
If the following apply to you, please the date of treatment and a short description:
Joint Replacement: ____
Heart Valve Replacement: ____
Serious Illness/Trauma: ____

Heath Conditions

____ AIDS/HIV
____ Alzheimer's
____ Anemia
____ Asthma
____ Bleeding problems
____ Cancer
____ Cold sores
____ Diabetes
____ Dry Mouth
____ Epilepsy/Seizures
____ GERD
____ Headaches
____ Heart Failure/Attack
____ High Blood Pressure
____ Jaw Joint Pain
____ Osteoporosis
____ Pacemaker
____ Psychiatric Care
____ Endocarditis
____ Respiratory Disease
____ Hepatitis
____ Ulcers
____ Stroke
____ Herpes
____ Implants
____ Sleep Apnea
____ Drug Addiction
____ Alcoholism
____ Kidney Disease
____ Chemotherapy
____ Radiation Tx
____ Thyroid Disease
____ Rheumatic Fever
____ Scarlet Fever
____ Tuberculosis
____ Venereal Disease

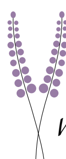
____ Pregnancy ____ Nursing ____ Birth Control

Any other medical condition not listed: ____

Signature: ____ **Date**: _________________________

Office use only:

Reviewed By: ______________________________________ Date: _________________________



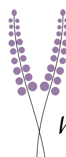
Wyatt Family Dental Care
Cherylin H. Wyatt, DDS

Office Policies

- ✦ We reserve time in the doctor or hygienist's schedule especially for you. Appointments cancelled on short notice are very difficult to fill. Please provide at least 2 business days' notice to cancel or reschedule your appointment. Appointments cancelled or rescheduled with less than two business days' notice will incur a charge of $75.00.
- ✦ Payment is due at the time that services are provided. Financial arrangements must be made prior to your appointment, including a completed a financial agreement.
- ✦ As a courtesy, our office will submit bills to your insurance or benefits plan, and help prepare insurance forms for collection. We will also credit such collections to your account. For these reasons, you hereby authorize your insurance company to directly pay our office.
- ✦ Our office cannot provide services to you based upon the presumption that charges will be paid by an insurance company. So if you have insurance, then it remains your responsibility to understand your benefits. If your insurance or benefit carrier pays less than the bill for services, then it remains your responsibility to pay the balance. If an insurance claim is not received in full within 60 days of treatment, then it remains your responsibility to submit payment in full. The same applies if your treatment is not covered by your insurance or benefits carrier.
- ✦ By signing, you acknowledge that the information that you provided is correct. You also authorize this office to perform any dental services that you may need or request, and acknowledge that you gave your consent to this treatment.
- ✦ By signing, you acknowledge that a copy of this office's Notice of Privacy Practices was made available to you, and that you received an opportunity to ask any questions about it.
- ✦ By signing, you acknowledge that a copy of this office's Dental Material Fact Sheet was made available to you, and that you received an opportunity to ask any questions about it.
- ✦ By signing, you authorize Wyatt Dental Corporation to release any information, including diagnosis and record of any treatment or examination provided to you or your child, to third party payors or health practitioners.

Thank you for visiting our family-owned dental practice! We look forward to keeping you healthy in the years ahead.

Signature: ____ **Date**: __________________________



Wyatt Family Dental Care

Cherylin H. Wyatt, DDS