# Ronald G. Willis, DMD

## *Health and Dental History*

### *Patient Information:*

Mr. Mrs. Miss. Dr. (Circle One)

Name_____ Social Security #_____

Address_____ City_____ State_____Zip_____

Home Phone_____ Work Phone_____

Cell Phone_____ D.O.B._____

Drivers License_____ E-Mail_____

Female_____ Male_____ Occupation_____

Spouse's Name_____ Phone #_____

Emergency Contact_____ Emergency #_____

### *Responsible Party:*

Name_____ Social Security #_____

Home Phone_____ Work Phone_____

Cell Phone_____ Drivers License_____

### *Primary Insurance:*

Insurance Company_____ Insurance Address_____

Insured's Name_____ Insured's Social Security #_____

Insured's Employer_____ Group #_____

Insured's D.O.B._____ Is your Ins: HMO_____PPO_____Indemity_____

### *How did you hear about our office? (Please check one of the following)*

| | | | |
|---|---|---|---|
| *__Tallahassee Magazine* | *__Office Website* | *__Tallahassee Democrat* | *__Yellow Pages* |
| *__Your Health Magazine* | *__Tallahassee.com* | *__Phone Book* | *Other:_____* |
| *__Home & Design Magazine* | *__Google/Yahoo* | *__Word of Mouth* | *_____* |

### *Previous Dental Office:*

Date of your last dental exam:_____ By Whom:_____

What caused you to leave? _____

***At what point do you want to initiate treatment? (Please circle one of the following)***

When my tooth hurts or breaks When initial decay is present When something isn't ideal

***What quality of dentistry do you want us to recommend? (Please circle one of the following)***

"Just patch it" Average Ideal/Best

***Do you have or have you had any disease, condition, or problem that is not listed?***

_____

***Is there anything about your smile that you would like to improve?***

_____

***Please list any other concerns not covered that you would like to discuss:***

_____

***Have you been under the care of a medical doctor during the past 2 years*? Yes No**

***If so, for what?***_____

***Physicians Name:_____ Phone #_____***

***Are you taking any medications now, including regular doses of Aspirin or Fosamax?*** **Yes** **No**

***If so, Please list:_____***

***Are you aware of having any allergic reaction to a medication or drug?*** **Yes** **No**

***If so, please list:_____***

(For Example: Penicillin, Sulfa drugs, Latex, Codeine, Aspirin, Etc.)

## *Please indicate, by circling, which of the following you have had:*

| | | | | | |
|---|---|---|---|---|---|
| Heart Condition | Yes | No | Headaches | Yes | No |
| Congenital Heart Disease | Yes | No | Jaw Pain | Yes | No |
| Heart Murmur | Yes | No | Jaw Popping | Yes | No |
| Mitral Valve Prolapse | Yes | No | Limited Opening | Yes | No |
| Artificial Heart Valve | Yes | No | Congested Ears | Yes | No |
| High Blood Pressure | Yes | No | Dizziness | Yes | No |
| Pacemaker | Yes | No | Ringing Ears | Yes | No |
| Stroke | Yes | No | Loose Teeth | Yes | No |
| Asthma | Yes | No | Posture Problems | Yes | No |
| Liver Disease/Jaundice | Yes | No | Clenching | Yes | No |
| Thyroid | Yes | No | Grinding | Yes | No |
| Latex Sensitivity | Yes | No | Facial Pain | Yes | No |
| Artificial Joints | Yes | No | Sensitive Teeth | Yes | No |
| Kidney Trouble | Yes | No | Sensitive Teeth (hot/cold/pressure) | Yes | No |
| Radiation/Chemotherapy | Yes | No | Neck Pain | Yes | No |
| Epilepsy/Seizures | Yes | No | Bell's Palsy | Yes | No |
| Diabetes | Yes | No | Difficulty Swallowing | Yes | No |
| Hepatitis | Yes | No | Difficulty Chewing | Yes | No |
| AIDS/HIV | Yes | No | Tingling in Arms | Yes | No |
| Sickle Cell Disorders | Yes | No | Have you had braces? | Yes | No |
| Insomnia/Frequent Walking | Yes | No | Psychiatric/Psychological | Yes | No |
| Do you see a chiropractor? | Yes | No | Bleeding Clotting Disorders | Yes | No |
| Communicable Diseases: Tuberculosis, Herpes or Venereal | | | | Yes | No |
| Does floss shred when you use it? | | | | Yes | No |
| Does food pack or catch between your teeth? | | | | Yes | No |
| Do you smoke or chew tobacco? | | | | Yes | No |
| Do your gums bleed? | | | | Yes | No |
| Does your breath concern you? | | | | Yes | No |
| Unhealed injuries or inflamed areas in or around your mouth? | | | | Yes | No |
| Have you experienced any growths on sore spots in your mouth? | | | | Yes | No |
| History of Osteoporosis or Osteopenia? | | | | Yes | No |
| Have you ever had Botox? | | | | Yes | No |
| Have you ever had Dermal Fillers? | | | | Yes | No |

***Women:*** Are you pregnant? _____Nursing? _____Taking Birth Control Pills?_____

-I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you may have my permission to ask the respective health care provider, who may release such information to you. I will notify the doctor of any changes in my health. (New patients, a copy of your photo I.D. and insurance card (if applicable) are required at check in. Please present them to the receptionist.)

Signature:_____ Date:_____