Wagner Denture Group

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Patient information

Name _____ Preferred name _____ Birth date _____

If a minor, parents' names _____ Home phone _____ Cell phone _____

Mailing address _____ City _____ State _____ ZIP _____

Email _____ Employer _____ Work phone _____

Spouse's name _____ Spouse's employer _____

How did you hear about us, or who referred you? _____ ☐ DD Waiver

INSURANCE

We do not ask for Social Security numbers on this form, but will ask for it in person at the office.

☐ Dental ☐ Medical ☐ Medicare ☐ SR plan ☐ Tricare ☐ PPO ☐ HMO

Primary insurance company _____ Group number _____ Member ID _____

Secondary insurance company _____ Group number _____ Member ID _____

Subscriber's name, if not you (for example, a spouse) _____ Subscriber's birth date _____

MEDICAL HISTORY

Do you have, or have you had, any of the following?

- ☐ Cancer or tumor
- ☐ Heart ailment or angina
- ☐ Heart murmur, mitral valve prolapse, heart defect
- ☐ Rheumatic fever or rheumatic heart disease
- ☐ Artificial joint or valve
- ☐ High or low blood pressure
- ☐ Pacemaker
- ☐ Tuberculosis or other lung problems
- ☐ Kidney disease
- ☐ Hepatitis or other liver disease
- ☐ Alcoholism
- ☐ Blood transfusion
- ☐ Diabetes
- ☐ Neurologic condition
- ☐ Epilepsy, seizures, or fainting spells
- ☐ Emotional condition, anxiety
- ☐ Arthritis
- ☐ Herpes or cold sores
- ☐ AIDS or HIV positive
- ☐ Migraine or frequent headaches
- ☐ Anemia or blood disorders
- ☐ Abnormal bleeding after extractions, surgery, or trauma
- ☐ Hay fever or sinus trouble
- ☐ Allergies or hives
- ☐ Asthma

Are you allergic to, or have you reacted badly to, any of the following?

- ☐ Latex
- ☐ Penicillin or other antibiotics
- ☐ Local anesthetics (Novocain)
- ☐ Codeine or other narcotics
- ☐ Sulfa drugs
- ☐ Barbiturates, sedatives, or sleeping pills
- ☐ Aspirin

Other _____

Do you smoke or use chewing tobacco? ☐ **Yes** ☐ **No**

Are you taking any of the following?

- ☐ Aspirin
- ☐ Anticoagulants (blood thinners)
- ☐ Antibiotics or sulfa drugs
- ☐ High blood pressure medicine
- ☐ Antidepressants or tranquilizers
- ☐ Insulin, Orinase, or other diabetes drug
- ☐ Nitroglycerin
- ☐ Cortisone or other steroids
- ☐ Osteoporosis (bone density) medicine

Other _____ Women: ☐ May be pregnant ☐ Taking contraceptives Expected delivery date _____

Any other disease, condition, or problem _____

Emergency contact _____ Phone _____

INSURANCE BENEFITS AND PAYMENT

By signing below, I authorize my insurance company to pay the dentist all insurance benefits otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges not paid by insurance.

Signature of patient or parent _____ Date _____