TRADE WINDS DENTAL
David R. Hennington, D.D.S.

We know you have many choices for dentists in our area. We are honored that you have selected our office.
To help us meet all your healthcare goals, please fill out this form completely.
If there is anything on this form which is unclear, feel free to ask us about it. We will be happy to assist you.

PATIENT INFORMATION

NAME (FIRST, MIDDLE, LAST): _____ TODAY'S DATE: _____
I PREFER TO BE ADDRESSED AS: _____ BIRTHDATE: _____

MAILING ADDRESS: _____ HOME PHONE: _____
CITY: _____ STATE: _____ ZIP: _____ CELL PHONE: _____

SS#: _____ STATE DRIVER'S LICENSE/ID #: _____

EMPLOYER: _____ WORK PHONE: _____
BUSINESS ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____

EMAIL ADDRESS: _____ ☐ *CHECK HERE TO SIGN UP FOR OUR **QUARTERLY** E-NEWSLETTER (VIA EMAIL)*

WHAT IS THE BEST WAY TO CONTACT YOU? ☐ HOME ☐ CELL ☐ WORK ☐ E-MAIL

PLEASE CHECK IF YOU ARE: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

IF STUDENT, NAME OF SCHOOL/COLLEGE: _____ STATUS: ☐ FULL-TIME ☐ PART-TIME

PERSON TO CONTACT IN CASE OF EMERGENCY: _____ PHONE: _____
RELATIONSHIP TO PATIENT: _____

WHOM MAY WE THANK FOR REFERRING YOU?
☐ WEB SEARCH ☐ VERIZON YELLOW PAGES ☐ NEWSPAPER
☐ SUPERPAGES.COM ☐ GEORGETOWN PHONEBOOK ☐ MAILER
☐ FRIEND/FAMILY _____ ☐ RADIO
☐ OTHER: _____

PLEASE TELL US WHAT'S IMPORTANT TO YOU IN FINDING A DENTIST: _____
_____
_____
_____

RESPONSIBLE PARTY (FIRST, MIDDLE, LAST): _____ ☐ *IF **SELF**, CHECK HERE AND PROCEED TO MEDICAL HISTORY SECTION ON BACK*
RELATIONSHIP TO PATIENT: _____ BIRTHDATE: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____

PLEASE CHECK IF: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

SS#: _____ STATE DRIVER'S LICENSE/ID #: _____ HOME PHONE: _____
EMAIL ADDRESS: _____ CELL PHONE: _____

RESPONSIBLE PARTY'S EMPLOYER: _____ WORK PHONE: _____
BUSINESS ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____

IS THE RESPONISBLE PARTY CURRENTLY A PATIENT IN OUR OFFICE? ☐ ☐ YES ☐NO

OVER PLEASE FOR PATIENT MEDICAL HISTORY

PATIENT'S PREFERRED PHARMACY: _____ **PHARMACY PHONE:** _____

1. Are you undergoing medical treatment now, or under a physician's care? ☐ YES ☐NO
If yes, please explain:
_____
_____

PHYSICIAN:_____
PHYSICIAN's PHONE: _____

2. Have you been hospitalized for a surgical operation or illness within the last 5 years? ☐ YES ☐NO
If yes, please explain:
_____
_____
_____

3. Have you had a serious head or neck injury? ☐ YES ☐NO

4. Are you taking any medication(s), including non-prescription medicine? ☐ YES ☐NO
If yes, please list the medications:
_____
_____
_____
_____

5. Do you take, or have you taken, Phen-fen or Redux? ☐ YES ☐NO

6. Have you ever taken Fosamax, Boniva, Actonel or any other medications containing biphosphonates? ☐ YES ☐NO

7. Are you on a special diet?
If yes, please explain:
_____

8. Are you allergic to, or have you had any reaction to, the following:

ASPIRIN	☐ YES	☐NO
CODEINE	☐ YES	☐NO
LOCAL ANESTHETICS	☐ YES	☐NO
PENICILLIN	☐ YES	☐NO
SULFA DRUGS	☐ YES	☐NO
SEDATIVES	☐ YES	☐NO
IODINE	☐ YES	☐NO
ANY METALS (i.e. NICKEL, MERCURY, ETC.)	☐ YES	☐NO
LATEX RUBBER	☐ YES	☐NO
ACRYLIC	☐ YES	☐NO
OTHER ANTIBIOTICS _____	☐ YES	☐NO
OTHER _____	☐ YES	☐NO

9. Do you use tobacco? ☐ YES ☐NO

10. Do you use controlled substances? ☐ YES ☐NO

11. WOMEN ONLY:

Are you pregnant?	☐ YES	☐NO
Are you trying to get pregnant?	☐ YES	☐NO
Are you taking oral contraceptives?	☐ YES	☐NO
Are you nursing?	☐ YES	☐NO

12. Do you have or have you had any of the following?

AIDS/HIV POSITIVE	☐ YES	☐NO	EXCESSIVE BLEEDING	☐ YES	☐NO	LUNG DISEASE	☐ YES	☐NO
ALZHEIMER'S DISEASE	☐ YES	☐NO	EXCESSIVE THIRST	☐ YES	☐NO	MITRAL VALVE PROLAPSE	☐ YES	☐NO
ANAPHYLAXIS	☐ YES	☐NO	FAINTING SPELLS/DIZZINESS	☐ YES	☐NO	OSTEOPOROSIS	☐ YES	☐NO
ANEMIA	☐ YES	☐NO	FREQUENT COUGH	☐ YES	☐NO	PAIN IN JAW JOINTS	☐ YES	☐NO
ANGINA	☐ YES	☐NO	FREQUENT DIARRHEA	☐ YES	☐NO	PARATHYROID DISEASE	☐ YES	☐NO
ARTHRITIS/GOUT	☐ YES	☐NO	FREQUENT HEADACHES	☐ YES	☐NO	PSYCHIATRIC CARE	☐ YES	☐NO
ARTIFICIAL HEART VALVE	☐ YES	☐NO	GENITAL HERPES	☐ YES	☐NO	RADIATION TREATMENTS	☐ YES	☐NO
ARTIFICAL JOINT	☐ YES	☐NO	GLAUCOMA	☐ YES	☐NO	RECENT WEIGHT LOSS	☐ YES	☐NO
ASTHMA	☐ YES	☐NO	HAY FEVER	☐ YES	☐NO	RENAL DIALYSIS	☐ YES	☐NO
BLOOD DISEASE	☐ YES	☐NO	HEART ATTACK/FAILURE	☐ YES	☐NO	RHEUMATIC FEVER	☐ YES	☐NO
BLOOD TRANSFUSION	☐ YES	☐NO	HEART MURMUR	☐ YES	☐NO	RHEUMATISM	☐ YES	☐NO
BREATHING PROBLEM	☐ YES	☐NO	HEART PACEMAKER	☐ YES	☐NO	SCARLET FEVER	☐ YES	☐NO
BRUISE EASILY	☐ YES	☐NO	HEART TROUBLE/DISEASE	☐ YES	☐NO	SHINGLES	☐ YES	☐NO
CANCER	☐ YES	☐NO	HEMOPHILIA	☐ YES	☐NO	SICKLE CELL DISEASE	☐ YES	☐NO
CHEMOTHERAPY	☐ YES	☐NO	HEPATITIS A	☐ YES	☐NO	SINUS TROUBLE	☐ YES	☐NO
CHEST PAINS	☐ YES	☐NO	HEPATITIS B OR C	☐ YES	☐NO	SPINA BIFIDA	☐ YES	☐NO
COLD SORES/FEVER BLISTERS	☐ YES	☐NO	HERPES	☐ YES	☐NO	STOMACH/INTESTINE DISEASE	☐ YES	☐NO
CONGENTIAL HEART DISEASE	☐ YES	☐NO	HIGH BLOOD PRESSURE	☐ YES	☐NO	STROKE	☐ YES	☐NO
CONVULSIONS	☐ YES	☐NO	HIGH CHOLESTEROL	☐ YES	☐NO	SWELLING OF LIMBS	☐ YES	☐NO
CORTISONE MEDICINE	☐ YES	☐NO	HIVES OR RASH	☐ YES	☐NO	THYROID DISEASE	☐ YES	☐NO
DIABETES	☐ YES	☐NO	HYPOGLYCEMIA	☐ YES	☐NO	TONSILITIS	☐ YES	☐NO
DRUG ADDICTION	☐ YES	☐NO	IRREGULAR HEARTBEAT	☐ YES	☐NO	TUBERCULOSIS	☐ YES	☐NO
EASILY WINDED	☐ YES	☐NO	KIDNEY PROBLEMS	☐ YES	☐NO	TUMORS OR GROWTHS	☐ YES	☐NO
EMPHYSEMA	☐ YES	☐NO	LEUKEMIA	☐ YES	☐NO	ULCERS	☐ YES	☐NO
EPILEPSY OR SEIZURES	☐ YES	☐NO	LIVER DISEASE	☐ YES	☐NO	VENEREAL DISEASE	☐ YES	☐NO
			LOW BLODD PRESSURE	☐ YES	☐NO	YELLOW JAUNDICE	☐ YES	☐NO

AUTHORIZATION, RELEASE AND ACKNOWLEDGMENT

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. 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 child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits, as needed, otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for these services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I have been informed of the Notice of Privacy Practice for Trade Winds Dental, P.A. explaining my rights as a patient, and have been given an opportunity to review it. I understand the Notice of Privacy Practice is available online for viewing and printing at www.TradeWindsDental.com. I also understand I may request a copy of the Notice of Privacy Practice at any time. I understand electronic communications between Trade Winds Dental and me are not encrypted and the information may be vulnerable to interception.

☐ YES, you may... ☐NO, you may not... use my testimonial, photos and name to let other patients know about my great experience with your office.

X_____ _____
Patient Signature (or parent/guardian if minor) **Date**