1355 E Home Road
Springfield, OH 45503
937-390-2440

Patient Welcome

Atkins & Waldren D.D.S. INC.

Patient Information

Date: _____

Email: _____

Name: _____

Last First MI

Preferred Name: _____ ☐Male ☐Female

Home Address: _____

_____

City State OH

D.O.B.: _____ SS#: _____

☐Single ☐ Married ☐Divorced ☐Widowed ☐ Separated

Hm#: _____ Cell#: _____

Wk#: _____ Ext: _____

Employer: _____

Best time/place to reach you: _____

Emergency Contact: _____

Relation: _____

Wk#:_____

Cell#: _____

How did you find our office? _____

Previous Dentist: _____

_____

Last Visit There: _____

Spouse/Parent Information

Name: _____

Address: _____

_____

City State Zip

Wk#: _____ Ext: _____

SS#: _____ DOB: _____

Responsible Party

Name: _____

Relation: _____

_____

City State Zip

Employer: _____

Hm#: _____ Wk#: _____

SS#: _____

Insurance Coverage

Primary Dental Insurance

Insurance: _____

Address: _____

_____

City State ZIP

Ph#: _____ Group#: _____

Insured's Name: _____

Relation: _____ D.O.B.: _____

SS#: _____ Employer: _____

Secondary Dental Insurance

Insurance: _____

Address: _____

_____

City State ZIP

Ph#: _____Group#: _____

Insured's Name: _____

Relation: _____ D.O.B.: _____

SS#: _____ Employer: _____

Medical History

Personal Physician _____

Physician's Phone _____

Your current physical health is ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician?

☐ Yes ☐ No

Please explain _____

Presently taking any prescribed or over the counter medications? ☐ Yes ☐ No

Please list each one _____

_____

_____

Smoke or use tobacco in any form? ☐ Yes ☐ No

Vape? ☐ Yes ☐ No

Women: Birth Control Pills? ☐ Yes ☐ No

Pregnant? ☐ Yes ☐ No Weeks _____

Nursing? ☐ Yes ☐ No

Y N Abnormal Bleeding
Y N Acid Reflux
Y N Alcohol/Drug Abuse
Y N Anemia
Y N Aneurysm
Y N Arthritis
Y N Artificial Bones/Joints/ Valves
Y N Asthma
Y N Autism/Asperger's
Y N Autoimmune Diseases
Y N Blood Transfusion
Y N Breathing Difficulty
Y N Cancer/Chemotherapy
Y N Colitis/Crohn's
Y N Congenital Heart Defect
Y N Diabetes
Y N Emphysema/COPD
Y N Epilepsy/Seizures
Y N Fainting Spells
Y N Frequent Headaches
Y N Gastric Bypass Surgery
Y N Glaucoma
Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery
Y N Hemophilia
Y N Hepatitis
Y N Herpes/Fever Blisters
Y N High Blood Pressure
Y N HIV+/AIDS
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Mitral Valve Prolapse
Y N Neurological Disorders: MS, Parkinson's
Y N Osteoporosis
Y N Organ Transplant
Y N Pacemaker
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic/Scarlet Fever
Y N Sexually Transmitted Diseases
Y N Shingles
Y N Sickle Cell Disease/Traits
Y N Sinus Problems
Y N Sleep Apnea/CPAP
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis (TB)
Y N Ulcers

Are you allergic to any of the following?

Y N Aspirin Y N Erythromycin Y N Metals
Y N Codeine Y N Jewelry Y N Latex
Y N Penicillin Y N Tetracycline
Y N Dental Anesthetics

Please list any other drugs/materials you are allergic to:

_____

Please list any serious medical conditions you have had:

_____

Surgeries in the last six months: _____

_____

Dental History

Why have you come to our office today? _____

_____

_____

Do you require antibiotics before dental treatment?

☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had a serious/difficult problem associated with any previous dental treatment? ☐ Yes ☐ No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. I understand I am responsible for any payment my insurance does not cover.

I understand that a 1.5% interest fee may be charged for any account over 90 days past due.

I understand that once an appointment has been made, it is a time reserved just for me. Atkins & Waldren D.D.S., Inc reserves the right to charge a $50 fee for all cancelled or missed appointments without a 24 hour notice.

Payment is due in full at the time of visit unless prior arrangements have been approved.

Signature _____ Date _____

1. Date _____ Comments _____ Signature _____
2. Date _____ Comments _____ Signature _____
3. Date _____ Comments _____ Signature _____