Distinctive Dental Solutions
Health • Beauty • Comfort • Function

Thomas S. Walther, D.D.S.

CONFIDENTIAL PATIENT INFORMATION (Please complete the front and back of this sheet)

Patient Name: _____ Preferred Name (if different): _____
SSN: _____ Date of Birth: _____ **Email Address:** _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Marital Status: Other
Employer or School: _____ Occuaption: _____ Phone Number:_____
Spouse (Parents if Minor): _____ Date(s) of Birth: _____
Spouse Employer (Parents if Minor): _____ Phone Number: _____
How would you like your appointment confirmations/check-up reminders to be sent? ☐ Home Phone ☐ Cell Phone ☐ Email ☐ Text Message
Whom may we thank for referring you to Dr. Walther's office? _____

DENTAL INSURANCE INFORMATION

(This information is **required** if you have dental insurance. Thank you.)

Do you currently have dental insurance? ☐ YES ☐ NO Dental Insurance Company: _____
Insurance Policyholder: _____ Relationship to Patient: _____
Address of Policyholder: _____ City, State, Zip: _____
Date of Birth of Policyholder: _____ SSN:_____ Group #:_____
Do you have secondary dental insurance? ☐ YES ☐ NO Dental Insurance Company: _____

I prefer to pay for the patient portion of my dental treatment by: ☐ Cash ☐ Check ☐ Visa/MasterCard ☐ Care Credit

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the HEALTH INSURANCE PORTABILITY ACT OF 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and dentist certifications.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name (please print): _____ Signature:_____ Date: _____

OFFICE USE ONLY

Received by: _____ Date: _____

I attempted to obtain the patient's signature in acknowledgement on this NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT but was unable to do so as documented below.

Name: _____ Date: _____ Reason: _____
Signature of Doctor/Office Mangager: _____ Date:_____

DENTAL HEALTH HISTORY

Do you have any dental problems that bother you every day? ☐ YES ☐ NO Please Explain: _____

Do you bleed when you brush or floss your teeth? ☐ YES ☐ NO

Are your teeth sensitive to cold, hot, sweets or pressure? ☐ YES ☐ NO

Is your mouth dry? ☐ YES ☐ NO

Have you ever had orthodontic (braces) treatments? ☐ YES ☐ NO

Have you ever had any problems associated with previous dental treatment? ☐ YES ☐ NO

Do you have any difficulty sleeping? ☐ YES ☐ NO If yes, explain: _____

Do you grind your teeth? ☐ YES ☐ NO ☐ DON'T KNOW

Do you have any clicking, popping or discomfort in your jaw? ☐ YES ☐ NO

Do you wear dentures or partials? ☐ YES ☐ NO If YES, please explain: _____

Have you ever had a serious injury to your head, neck or jaw? ☐ YES ☐ NO

Date of your last dental exam: _____ Date of last dental x-rays: _____

Previous dentist (if applicable): _____ Phone Number: _____

How do you feel about your smile? _____

What, if anything, would you like to change about your smile? _____

MEDICAL HISTORY

Are you now under the care of a physician? ☐ YES ☐ NO

Physician Name: _____ Physician's Telephone Number: _____

Pharmacy: _____ Telephone Number: _____

Have you had a serious illness, operation or been hospitalized in the past 5 years? ☐ YES ☐ NO

If yes, what was the illness or problem? _____

Please list all **(including vitamins)** over the counter and prescription medications you are currently taking or have recently taken:

_____

Are you allergic to or have you had a reaction to (to all YES responses, please specify the reaction):

Local Anesthetics ☐ YES ☐ NO ☐ DON'T KNOW

Iodine ☐ YES ☐ NO ☐ DON'T KNOW

Penicillin/other antibiotics ☐ YES ☐ NO ☐ DON'T KNOW

Latex (rubber) ☐ YES ☐ NO ☐ DON'T KNOW

Metals ☐ YES ☐ NO ☐ DON'T KNOW

Other Allergies (please list): _____

Drug Allergies (please list): _____

Have you ever had (please check all that apply):

Heart Problems	☐ YES ☐ NO	Diabetes	☐ YES ☐ NO	Ear Trouble	☐ YES ☐ NO
High Blood Pressure	☐ YES ☐ NO	Sinus Problems	☐ YES ☐ NO	A.D.D.	☐ YES ☐ NO
* Heart Murmur	☐ YES ☐ NO	Hepatitis (Type ___)	☐ YES ☐ NO	Epilepsy	☑ YES ☐ NO
* Mitral Valve Prolapse	☐ YES ☐ NO	Stroke	☐ YES ☐ NO		
* Heart Valve Replacement	☐ YES ☐ NO	Excessive Bleeding	☐ YES ☐ NO		
*Rheumatic Fever	☐ YES ☐ NO	*Joint Replacement	☐ YES ☐ NO		
HIV Positive	☐ YES ☐ NO	Joint: _____	Date of Replacement: _____		

(*) May require Premedication with antibiotics prior to dental treatment.

Other Medical Issues: _____

WOMEN ONLY: Pregnant? ☐ YES ☐ NO ☐ DON'T KNOW Taking Birth Control Pills? ☐ YES ☐ NO

Number of weeks _____ Nursing? ☐ YES ☐ NO

I certify that I have read and understand the above and that the information given on this form is accurate. I understand that the importance of a truthful history and that my dentist and his staff will rely on this information for treating me.

Signature of Patient/Legal Guardian: _____ Date: _____

Signature of Doctor: _____ _____ Date: _____