MICHAEL V. WOOLWINE D.D.S.

1500 West 38th Street, Ste. 14
Austin, TX 78731
(512) 452-5713

Welcome!

The benefits of a healthy, happy smile are immeasurable! Our main goal is to help you achieve and maintain your maximum oral health and a smile you are proud to show off. Please fill out this form as completely as possible. We want to make sure that we are well informed about your medical history, current medications and any other factor that might affect your dental health and treatment. The better we communicate, the better able we are to take great care of you.

About You

Today's Date_____

How did you hear about us? _____

Name (First, Middle, Last): _____

I prefer to be addressed as:_____ Circle one: **M F**

Birth date: _____ Age: _____SS#_____

Address: _____

City: _____State: _____Zip: _____

Email Address: _____

Home Phone: _____Cell Phone: _____

Work Phone: _____

Employer: _____ Occupation: _____

Employer's Address: _____

City: _____State: _____Zip: _____

Circle one: **Single Married Widowed Divorced Separated Partnered**

Spouse's Name: _____

Spouse's Birthday: _____SS#_____

Spouse's Employer: _____Occupation: _____

When and where are the best times to reach you?

_____

Other Family Members seen by us: _____

Dental Insurance

If you have dental insurance, please give us the info on page 3!

Emergency Contact

Name: _____Relationship: _____

Home Phone: _____Cell #_____

Does your emergency contact live with you? **Yes No**

Acknowledgements & Signatures

I acknowledge that the information I give in this form is correct to the best of my knowledge. This information will be held in the strictest confidence. I will inform the office of any change to my insurance or medical status.

Signature: _____

Date: _____

I understand that I will be required to pay my **estimated** portion of Dr. Woolwine's fees at the time of treatment unless prior arrangements have been made. I also understand that I am ultimately responsible for payment of any and all services rendered, regardless of insurance reimbursements.

Signature: _____

Date: _____

Medical History

Do you have a physician? **Yes No** Physician's Name: _____Phone: _____

Date of Last Physical: _____ Current Physical Health: **Excellent Good Fair Poor Very Poor**

Are you currently under the care/supervision of a physician? **Yes No**

Please Explain: _____

Are you currently taking any prescription medications? **Yes No**

Please list all medications with correlating diagnosis: _____

_____

_____

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For Women: Are you taking birth control pills? **Yes No** Are you pregnant? **Yes No** Are you nursing: **Yes No**

Do you or have you ever used tobacco in any form? **Yes No** If yes, how much? _____For how long? _____

Allergies: Circle any and all of the following to which you are allergic:

Aspirin Barbiturates/Sleeping Pills Codiene Dental Anesthetics Erythromycin Ibuprophen/Motrin Jewelry/Metals Latex Percocet Penicillin Tetracycline Vicodin

List any other Medications and /or Materials to which you think you might be allergic: _____

Medical Conditions:

Have you ever had any of the following Medical conditions? Circle Yes or No

Abnormal Bleeding	**Yes No**	Frequent Headaches	**Yes No**	Mitral Valve Prolapse	**Yes No**
Alcohol or Drug Abuse	**Yes No**	Glaucoma	**Yes No**	Osteoporosis	**Yes No**
Anemia	**Yes No**	Hay Fever	**Yes No**	Pacemaker	**Yes No**
Arthritis	**Yes No**	Heart Attack	**Yes No**	Psychiatric Problems	**Yes No**
Artificial Bones/Joints	**Yes No**	Heart Murmur	**Yes No**	Radiation Treatment	**Yes No**
Asthma	**Yes No**	Heart Surgery	**Yes No**	Rheumatic/Scarlet Fever	**Yes No**
Blood Transfusion	**Yes No**	Hemophilia	**Yes No**	Seizures	**Yes No**
Cancer/Chemotherapy	**Yes No**	Hepatitis	**Yes No**	Shingles	**Yes No**
Colitis	**Yes No**	Herpes/Fever Blisters	**Yes No**	Sickle Cell Disease	**Yes No**
Congenital Heart Disease	**Yes No**	High Blood Pressure	**Yes No**	Sinus Problems	**Yes No**
Diabetes	**Yes No**	HIV or AIDS	**Yes No**	Stroke	**Yes No**
Difficulty Breathing	**Yes No**	Hospitalized for any reason (If yes please explain below)			**Yes No**
Emphysema	**Yes No**	Kidney Problems	**Yes No**	Thyroid Problems	**Yes No**
Epilepsy	**Yes No**	Liver Disease	**Yes No**	Tuberculosis/TB	**Yes No**
Fainting Spells	**Yes No**	Low Blood Pressure	**Yes No**	Ulcers	**Yes No**

Please explain any serious medical conditions you have ever had: _____

_____

Why have you come to our office today? _____ Are you in pain? _____

Previous Dentist_____Phone:_____Last visit date: _____

What was done? _____ Date of Last Cleaning: _____Date of Last Dental X-Rays_____

Have you ever been told you require antibiotics before dental treatment? **Yes No**

Do you have or have you ever had any of the following conditions, ailments, or treatments? Circle Yes or No.

Bad Breath	**Yes No**	Food Collection Area	**Yes No**	Orthodontics	**Yes No**
Bleeding Gums	**Yes No**	Grinding Teeth	**Yes No**	Pain Around Ear	**Yes No**
Blisters on Lips or Mouth	**Yes No**	Gums Swollen	**Yes No**	Periodontal Treatment	**Yes No**
Broken Fillings	**Yes No**	Jaw Pain	**Yes No**	Sensitive to Cold	**Yes No**
Clenching of Teeth	**Yes No**	Jaw Fatigue	**Yes No**	Sensitive to Heat	**Yes No**
Jaw Clicking or Popping	**Yes No**	Lip or Cheek biting	**Yes No**	Sweet Sensitivity	**Yes No**
Dry Mouth	**Yes No**	Loose Teeth	**Yes No**	Sore in Mouth	**Yes No**

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

Do you ever experience pain in your jaw joint (TMJ/TMD)? **Yes** **No**

How would you classify your current dental health? **Excellent** **Good** **Fair** **Poor** **Very Poor**

On a scale of 1-10, how would you rate your smile? (10 being the best) _____

Would you like whiter teeth? **Yes** **No** Would you like fresher breath? **Yes** **No**

What else about your smile would you like to change?

_____

_____

Person responsible for your account other than yourself:

_____

_____

Dental Insurance Information:

Do you have Dental Insurance Coverage? **Yes** **No**

Dental Insurance Company Name: _____

Dental Insurance Company Address: _____

City: _____State: _____Zip: _____

Dental Insurance Company Phone #_____

Your Group #_____

Your Employee ID #_____

Insured's Name: _____ Relationship: _____

Insured's Birthday: _____ Social Security Number: _____

Alternate ID #_____

Insured's Employer: _____

Good Contact # of Insured _____

********Please tell us if you have a secondary dental insurance coverage.***

If possible, please bring your dental insurance card or insurance information for our records.