



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): _____
I PREFER TO BE ADDRESSED AS: _____

TODAY'S DATE: _____
BIRTHDATE: _____

MAILING ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____
CELL PHONE: _____

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

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

WORK PHONE: _____

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: _____
RELATIONSHIP TO PATIENT: _____

PHONE: _____

WHOM MAY WE THANK FOR REFERRING YOU? GOOGLE YAHOO 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): _____
RELATIONSHIP TO PATIENT: _____ BIRTHDATE: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____

IF SELF, CHECK HERE AND PROCEED TO
MEDICAL HISTORY SECTION ON BACK

PLEASE CHECK IF: MINOR SINGLE MARRIED DIVORCED WIDOWED

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

HOME PHONE: _____
CELL PHONE: _____

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

WORK PHONE: _____

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

PATIENT MEDICAL HISTORY

PHYSICIAN: _____

PHYSICIAN'S PHONE: _____

PREFERRED PHARMACY: _____

PHARMACY PHONE: _____

1. Are you undergoing medical treatment now, or under a physician's care?
If yes, please explain: _____

YES NO

2. Have you been hospitalized for a surgical operation or illness within the last 5 years?
If yes, please explain: _____

YES NO

3. Are you taking any medication(s) including non-prescription medicine?
If yes, what medications are you taking? _____

YES NO

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

LOCAL ANESTHETICS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
PENICILLIN OR ANY OTHER ANTIBIOTICS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
SULFA DRUGS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
CODEINE	<input type="checkbox"/> YES	<input type="checkbox"/> NO
SEDATIVES	<input type="checkbox"/> YES	<input type="checkbox"/> NO
IODINE	<input type="checkbox"/> YES	<input type="checkbox"/> NO
ANY METALS (i.e. NICKEL, MERCURY, ETC.)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
LATEX RUBBER	<input type="checkbox"/> YES	<input type="checkbox"/> NO
OTHER _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO

5. Do you use tobacco?

YES NO

6. WOMEN ONLY:

Are you pregnant?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Are you nursing?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Are you taking oral contraceptives?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

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

PSYCHIATRIC PROBLEMS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	ABNORMAL BLEEDING	<input type="checkbox"/> YES	<input type="checkbox"/> NO	JOINT REPLACEMENT/IMPLANT	<input type="checkbox"/> YES	<input type="checkbox"/> NO
HIGH BLOOD PRESSURE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	TUBERCULOSIS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	MITRAL VALVE PROLAPSE	<input type="checkbox"/> YES	<input type="checkbox"/> NO
HEART DISEASE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	CONVULSIONS/SEIZURES	<input type="checkbox"/> YES	<input type="checkbox"/> NO	KIDNEY DISEASE	<input type="checkbox"/> YES	<input type="checkbox"/> NO
STOMACH TROUBLES	<input type="checkbox"/> YES	<input type="checkbox"/> NO	ANEMIA	<input type="checkbox"/> YES	<input type="checkbox"/> NO	HEPATITIS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
HEART ATTACK	<input type="checkbox"/> YES	<input type="checkbox"/> NO	RADIATION/CHEMOTHERAPY	<input type="checkbox"/> YES	<input type="checkbox"/> NO	AIDS/HIV	<input type="checkbox"/> YES	<input type="checkbox"/> NO
CARDIAC PACEMAKER	<input type="checkbox"/> YES	<input type="checkbox"/> NO	ASTHMA	<input type="checkbox"/> YES	<input type="checkbox"/> NO	JAUNDICE	<input type="checkbox"/> YES	<input type="checkbox"/> NO
ALCOHOL ABUSE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	EMPHYSEMA	<input type="checkbox"/> YES	<input type="checkbox"/> NO	THYROID PROBLEM	<input type="checkbox"/> YES	<input type="checkbox"/> NO
RHEUMATIC FEVER	<input type="checkbox"/> YES	<input type="checkbox"/> NO	GLAUCOMA	<input type="checkbox"/> YES	<input type="checkbox"/> NO	SEXUALLY TRANSMITTED DISEASE	<input type="checkbox"/> YES	<input type="checkbox"/> NO
HEART MURMUR	<input type="checkbox"/> YES	<input type="checkbox"/> NO	LOW BLOOD PRESSURE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	OTHER _____		
STROKE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	CANCER	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____		
ARTIFICIAL HEART VALVE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	CONGENITAL HEART DEFECT	<input type="checkbox"/> YES	<input type="checkbox"/> NO	OTHER _____		
ANGINA	<input type="checkbox"/> YES	<input type="checkbox"/> NO	LEUKEMIA	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____		
SINUS PROBLEMS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	ARTHRITIS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____		
FAINTING	<input type="checkbox"/> YES	<input type="checkbox"/> NO	DIABETES	<input type="checkbox"/> YES	<input type="checkbox"/> 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.

YES, you may 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

For TRADE WINDS DENTAL use only: