John D. Wells, D.D.S., P.A.

Specialist in Endodontics

16600-B Birkdale Commons Pkwy
Huntersville, NC 28078
704-987-9888

Date _____

Patient Information (CONFIDENTIAL)

Name_____ Birthdate _____ Home Phone_____

Address _____ City _____ State/Prov._____ Zip/P.C._____

Email_____ Cell Phone _____

Check Appropriate Box: ❒ Minor ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Separated

Patient or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ Prov._____ P.C._____

State/ Zip/

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone_____

Responsible Party (If other than the patient)

Name of Person Responsible for this Account_____ Relationship to Patient_____

Address_____ Home Phone_____

Email_____ Cell Phone_____

Birthdate_____

Employer_____ Work Phone_____ SS#/SIN_____

Is this person currently a patient in our office? ❒ Yes ❒ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

❒ Cash ❒ Personal Check Credit Card ❒ VISA ❒ MasterCard ❒ Discover ❒ American Express ❒ Care Credit

Dental Insurance Information

Name of Insured_____ Relationship to Patient_____

Birthdate_____ SS#/SIN _____ Date Employed_____

Name of Employer _____ Work Phone_____

Address of Employer _____ City_____ State/Prov._____ Zip/P.C._____

Insurance Company _____ Group#_____ Policy/ID#_____

Ins. Co. Address_____ City_____ State/Prov._____ Zip/P.C._____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit_____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ❒ Yes ❒ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured_____ Relationship to Patient_____

Birthdate_____ SS#/SIN _____ Date Employed_____

Name of Employer _____ Work Phone_____

Address of Employer _____ City_____ State/Prov._____ Zip/P.C._____

Insurance Company _____ Group#_____ Policy/ID#_____

Ins. Co. Address_____ City_____ State/Prov._____ Zip/P.C._____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit_____

Over Please

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Patient Medical History

*Physician*_____ *Office Phone*_____*Date of Last Exam*_____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitilized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain_____		
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
List_____		
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
6. Have you ever taken Viagra, Revati, Cialis or Levitra in the last 24 hours?	☐	☐
7. Do you use tobacco?	☐	☐
8. Do you use controlled substances?	☐	☐
9. Do you take Blood thinners?	☐	☐

	Yes	No
10. Are you wearing contact lenses?	☐	☐
11. Are you allergic to or have you had reactions to the following?	☐	☐
Local Anesthetics (e.g. Novacain)	☐	☐
Penicillin, Tetracyclines or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list)_____	☐	☐
12. **Women Only:**		
a.) Are you pregnant or think you may be pregnant	☐	☐
b.) Are you nursing	☐	☐
c.) Are you taking oral contraceptives?	☐	☐

Do you or have you had any of the following?

	Yes	No
Rheumatic Fever	☐	☐
Heart Murmur	☐	☐
Joint Replacement or Implant	☐	☐
Mitral Valve Prolapse	☐	☐
Artificial Heart Valves (stunts or conduits)	☐	☐
History of Infective Endocarditis	☐	☐
Serious Congential Heart Conditions	☐	☐
High Blood Pressure	☐	☐
Heart Attack	☐	☐
Swollen Ankles	☐	☐
Fainting/Seizures	☐	☐
Asthma	☐	☐
Low Blood Pressure	☐	☐

	Yes	No
Epilepsy / Convulsions	☐	☐
Leukemia	☐	☐
Diabetes	☐	☐
Kidney Diseases	☐	☐
AIDS or HIV Infection	☐	☐
Thyroid Problem	☐	☐
Heart Disease	☐	☐
Cardiac Pacemaker	☐	☐
Angina	☐	☐
Emphysema	☐	☐
Cancer	☐	☐
Hepatitis / Jaundice	☐	☐
Sexually Transmitted Disease	☐	☐

	Yes	No
Stomach Troubles/ Ulcers	☐	☐
Chest Pains	☐	☐
Stroke	☐	☐
Tuberculosis	☐	☐
Radiation Therapy	☐	☐
Liver Disease	☐	☐
Heart Trouble	☐	☐
Respiratory Problems	☐	☐
Other_____	☐	☐

Current Dental Concern

Area of Concern: *Top Right* _____ *Bottom Right* _____
Top Left _____ *Bottom Left* _____
Top Front _____ *Bottom Front* _____

Type of Pain: *Mild* _____ *Moderate* _____ *Severe* _____
Pain Occurs to: *Cold* _____ *Hot* _____ *Biting* _____
*For no reason*_____
Is there Swelling? *Yes* _____ *No* _____

Authorization and Release

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 payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

X_____

Signature of patient (or partent/guardian if minor) *Date*

Doctor's Comments _____

_____

_____*Signature*_____ *Date* _____