

# Warner & Warner, PLLC

Danny G. Warner, DDS  
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## PATIENT INFORMATION

Date \_\_\_\_\_  
Name \_\_\_\_\_ Name Preference \_\_\_\_\_ Birthdate \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Patient's or Parent's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Spouse or Parent's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Whom may we thank for referring you ? \_\_\_\_\_  
Person to contact in case of an emergency \_\_\_\_\_ Phone \_\_\_\_\_  
Would you like to receive our newsletter via Email ?  Yes  No

## RESPONSIBLE PARTY

Name of person responsible for this account \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
Driver's License # \_\_\_\_\_ Birthdate \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

## DENTAL INSURANCE INFORMATION

Name of insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_  
Name of Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Union or Local # \_\_\_\_\_  
Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Do you have any additional dental insurance?**  Yes  No **If yes, complete the following:**

Name of insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_  
Name of Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Union or Local # \_\_\_\_\_  
Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**DENTAL HISTORY**

Reason for today's visit : \_\_\_\_\_

When was your last dental visit : \_\_\_\_\_

What was the approximate date of your last dental x-rays: \_\_\_\_\_

Have you ever had any serious complications with prior dental treatment? **Yes** **No**  
If Yes, What? \_\_\_\_\_

Do you have any concerns about the appearance of your teeth? **Yes** **No**  
If yes, explain: \_\_\_\_\_

Have you ever bleached your teeth? **Yes** **No**

What type of toothbrush do you use : Soft  Medium  Hard  Electric

\* please circle the answer for **each question** listed below:

- 1. Are you currently in pain? **Yes** **No**
- 2. Do you require antibiotics before dental treatment? **Yes** **No**
- 3. Do you brush daily? **Yes** **No**
- 4. Do you floss daily? **Yes** **No**
- 5. Do any of your teeth hurt when brushing or flossing them? **Yes** **No**
- 6. Do your gums ever bleed? **Yes** **No**
- 7. Are your teeth sensitive to hot, cold, sweet foods or liquids? **Yes** **No**
- 8. Does food get caught between your teeth? **Yes** **No**
- 9. Have you ever experienced any of the following problems in your jaw?  
Clicking: **Yes** **No**  
Pain (joint,ear,side of face): **Yes** **No**  
Difficulty opening/closing: **Yes** **No**

- 10. Have you had any head, neck or jaw injuries? **Yes** **No**
- 11. Do you have frequent headaches? **Yes** **No**
- 12. Do you clench or grind your teeth? **Yes** **No**
- Have you ever had:**
- 13. Orthodontic Treatment (Braces?) **Yes** **No**
- 14. Oral Surgery? **Yes** **No**
- 15. Your bite adjusted? **Yes** **No**
- 16. Worn a bite plate? **Yes** **No**
- 17. Are you under any unusual stress at home or work? **Yes** **No**
- 18. Do you experience stress when you visit the dentist? **Yes** **No**

**Summary of Dental History**  
**To be completed by the Doctor**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL HISTORY**

- A.** Are you in good health: **Yes No**
- B.** Have there been any changes in your general health within the past year: **Yes No**  
If so, explain: \_\_\_\_\_
- C.** Are you under the care of a physician: **Yes No**  
Physician's Name: \_\_\_\_\_
- D.** Have you ever been hospitalized for any surgical operation or illness: **Yes No**  
If yes, explain: \_\_\_\_\_
- E.** Are you currently taking medications including nonprescription medicine: **Yes No**  
Please list: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- F.** Have you had any abnormal bleeding? **Yes No**

- G.** Do you bruise easily: **Yes No**
- H.** Have you ever required a blood transfusion: **Yes No**
- I.** Do you use tobacco: **Yes No**
- J.** Do you use alcohol: **Yes No**
- K.** Do you have any disease, condition, or problem not listed above that you think I should know about: \_\_\_\_\_
- L.** Are you allergic to or have you had reactions to:  
Local anesthetics like novocaine: **Yes No**  
Penicillin: **Yes No**  
Sulfa Drugs: **Yes No**  
Aspirin: **Yes No**  
Iodine: **Yes No**  
Latex: **Yes No**  
Other Antibiotics: \_\_\_\_\_  
Other Allergies: \_\_\_\_\_

**Do you have, or have you ever had, any of the following:**

- |   |  |   |
|---|--|---|
| <b>1.</b> Rheumatic Fever <b>Yes No</b>               | <b>14.</b> Stroke <b>Yes No</b>                  | <b>27.</b> Kidney Trouble <b>Yes No</b>                     |
| <b>2.</b> Heart defect or heart murmur <b>Yes No</b>  | <b>15.</b> Breathing Problems <b>Yes No</b>      | <b>28.</b> Tuberculosis <b>Yes No</b>                       |
| <b>3.</b> Heart trouble or Heart Attack <b>Yes No</b> | <b>16.</b> Asthma <b>Yes No</b>                  | <b>29.</b> Cancer <b>Yes No</b>                             |
| <b>4.</b> Heart Surgery <b>Yes No</b>                 | <b>17.</b> Hay Fever <b>Yes No</b>               | <b>30.</b> Epilepsy <b>Yes No</b>                           |
| <b>5.</b> Joint Replacement <b>Yes No</b>             | <b>18.</b> Hives or Skin Rash <b>Yes No</b>      | <b>31.</b> Anemia <b>Yes No</b>                             |
| <b>6.</b> Scarlet Fever <b>Yes No</b>                 | <b>19.</b> Fainting Spells <b>Yes No</b>         | <b>32.</b> Leukemia <b>Yes No</b>                           |
| <b>7.</b> Shortness of breath <b>Yes No</b>           | <b>20.</b> Diabetes <b>Yes No</b>                | <b>33.</b> Eating Disorder <b>Yes No</b>                    |
| <b>8.</b> Pacemaker <b>Yes No</b>                     | <b>21.</b> AIDS or HIV Infection <b>Yes No</b>   | <b>Women Only:</b>  |
| <b>9.</b> High Blood Pressure <b>Yes No</b>           | <b>22.</b> Sinus Trouble <b>Yes No</b>           | <b>34.</b> Are you pregnant <b>Yes No</b>                   |
| <b>10.</b> Low Blood Pressure <b>Yes No</b>           | <b>23.</b> Thyroid Problems <b>Yes No</b>        | <b>35.</b> Are you nursing <b>Yes No</b>                    |
| <b>11.</b> Hepatitis <b>Yes No</b>                    | <b>24.</b> Allergies <b>Yes No</b>               | <b>36.</b> Are you taking birth control pills <b>Yes No</b> |
| <b>12.</b> Jaundice <b>Yes No</b>                     | <b>25.</b> Arthritis or Rheumatism <b>Yes No</b> |   |
| <b>13.</b> Liver Disease <b>Yes No</b>                | <b>26.</b> Acid Reflux <b>Yes No</b>             |   |

**Summary of Medical History  
To Be Completed By Doctor**

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**CANCELLATION POLICY**

Except in severe weather conditions or in extreme emergencies, a 24 hour notice is required for cancellation. Otherwise, patients will be responsible for payment for their appointment.

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 that it is my responsibility to inform this office of any changes.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_