Dr. William Moore
General Dentistry

WILLIAM U. MOORE, D.D.S., PLLC
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PATIENT INFORMATION

Date____________________

Name ______________________________ Home Phone (_____)______________

Street ______________________________ Cell Phone (_____)______________

City ______________________________ State________ Zip ____________

Date of Birth ______________________ Sex ______________________

SSN______________________ Email______________________________

INSURANCE INFORMATION

Do you have dental insurance? ☐ Yes ☐ No Insurance Name ______________________

ID#______________________ Group #______________________

Subscriber's Name ______________ Subscriber's DOB ____________ Subscriber's SSN ____________

Subscriber's Workplace ______________ Subscriber's Relationship ______________________

REFERRAL INFORMATION

Referred by ______________________ Family Dentist ______________________

Physician ______________________ Last Seen / Reason ______________________

DENTAL HISTORY

1. What is your biggest concern about your gums, mouth, or teeth?

2. When was your last visit to your family dentist and what was the nature of the treatment?

3. Have you had periodontal treatment before? If yes, when and where? ☐ Yes ☐ No

4. How often and when is the last time your teeth were cleaned?

Check the following conditions if they apply to you

☐ swollen or bleeding gums ☐ bad breath or mouth odors ☐ bad tastes
☐ painful gums or teeth ☐ sensitivity to hot, cold, or sweets ☐ clenching or grinding of your teeth
☐ loose teeth ☐ increasing spaces between teeth ☐ other______________

IMPORTANT: Have you ever been treated for thin bones **(Osteoporosis, Osteopenia)**? If yes, please check:

☐ ACTONEL ☐ FOSAMAX ☐ BONIVA ☐ ZOMETA
☐ SKELID ☐ OSTAC ☐ BONEFOS ☐ DIDRONEL

PLEASE EMAIL TO: frontdesk@WilliamMooreDentistry.com

MEDICAL HISTORY

Place check in the YES or NO boxes

Question	YES	NO
1. Are you allergic to any medications? If yes, what? ______	☐	☐
2. Have you had any serious illness, operation, or hospitalization in the past? Reason: ______	☐	☐
3. Has there been a change in your health in the last 2 years? ______	☐	☐
4. Are you a "bleeder" or have you had excessive bleeding following a dental treatment? ______	☐	☐
5. Are you presently under the care of a physician? If so, why? ______	☐	☐
6. Do you smoke or use tobacco products? How much?______ How long?______	☐	☐
7. Do you drink alcoholic beverages? ______	☐	☐
8. Have you had Cancer? Please describe. ______	☐	☐
9. Do you have any artificial joints? When & Type ______	☐	☐

10. **HAVE YOU HAD ANY OF THE FOLLOWING:**

	YES	NO		YES	NO		YES	NO
High Blood Pressure	☐	☐	Angina	☐	☐	AIDS or H.I.V.	☐	☐
Heart Murmurs	☐	☐	Heart Attack	☐	☐	Blood Disorders	☐	☐
Prolapsed Mitral Valve	☐	☐	Pacemaker	☐	☐	Nervous Disorders	☐	☐
Rheumatic Fever	☐	☐	Emphysema	☐	☐	Epilepsy / Seizures	☐	☐
Heart Problems	☐	☐	Asthma	☐	☐	Steroids Last 2 Years	☐	☐
Heart Bypass Surgery	☐	☐	Dialysis	☐	☐	Radiation / Chemo	☐	☐
Kidney Disease	☐	☐	Tuberculosis	☐	☐	Bleeding Problems	☐	☐
Chemical Dependency Treatment	☐	☐	Stroke	☐	☐			
Hepatitis / Liver Disease	☐	☐	Diabetes	☐	☐	**Women Only:**		
Oral Surgery Complications	☐	☐	Arthritis	☐	☐	Pregnant	☐	☐
Thyroid Disorders	☐	☐	Headaches	☐	☐	Breast Feeding	☐	☐

11. List **ANY** drugs or medicines that you are currently taking.

DRUG	DOSAGE / HOW OFTEN?	HOW LONG?
______	______	______
______	______	______
______	______	______
______	______	______

PATIENT SIGNATURE ______________________ DATE ______________

For Office Use:

MEDICAL HISTORY REVIEWED / UPDATED ON: ______________ DATE ______________