

Wildwood Dental Care
Robert S. Israel, D.D.S.

Smile Analysis

Last Name _____ First Name _____ Dr. Mr.
 Mrs. Ms.

Address _____

City _____ State _____ Zip _____

1. Date of last dental visit ? ____/____/____ Date of last dental xrays? ____/____/____

2. Reason for last visit? _____

3. Do you have any concerns about previous dental care or this dental visit? _____

4. On a scale of 1 to 10 (10 being the highest) how important is it for you to keep your teeth for the rest of your life? _____

5. What, if anything, would you change about your smile?

6. Do your gums bleed? Yes No

7. Are your teeth loose? Yes No

8. Have you ever been told that you have bad breath? Yes No

9. Are your teeth sensitive to (circle all that apply) Sweets Cold Heat Pressure

10. Do you like the color of your teeth? Yes No

11. Do you feel your teeth are starting to get longer? Yes No

12. Do you get food stuck between your teeth easily? Yes No

13. Do you ever experience tooth pain that is relieved by biting down on the affected area? Yes No

14. Do you ever experience mouth dryness related to medications or a health condition? Yes No

I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers that I have given are accurate. I also understand that it is very important to report any changes or updates in my medical status. I give permission to obtain from my physician any additional information regarding my medical history needed to provide me with the best treatment possible.

Patient Signature _____ Date _____

If you have completed this form for another person, please print your name and sign below along with your relationship to the patient:

Print _____ Relationship _____

Signature _____ Date _____

Wildwood Dental Care

Robert Israel, D.D.S.

1230 Satellite Blvd.

Suwanee, Georgia 30024

Phone (770) 476-9192

Fax (770) 476-9193

(For office use only)

Account ID _____

Date _____

Patient Health History

Personal Information

Patient Name: _____ DOB: _____ SSN: _____

*Name: Mr/Mrs/Miss/Ms _____ DOB: _____ SSN: _____

Spouse: Mr/Mrs/Miss/Ms _____ DOB: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Mobile Phone: _____

Referred By: _____

** Person Responsible for Account*

Email Address: _____

Employer Dental Insurance Information

Your Employer _____ Phone _____

Dental Insurance _____ Group No. _____

Address _____

Coverage Family Self and Dependents Self Only Children Only Parents Only

Spouse Employer _____ Phone _____

Dental Insurance _____ Group No. _____

Address _____

Coverage Family Self and Dependents Self Only Children Only Parents Only

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Medical History Information

Check the conditions that apply to you

Yes No	Yes No	Yes No	Allergic to:
<input type="checkbox"/> <input type="checkbox"/> Anemia/Blood Disease	<input type="checkbox"/> <input type="checkbox"/> Fainting/Nervous	<input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse	Yes No
<input type="checkbox"/> <input type="checkbox"/> Arthritis	<input type="checkbox"/> <input type="checkbox"/> Glaucoma	<input type="checkbox"/> <input type="checkbox"/> Neck/Head Pain	<input type="checkbox"/> <input type="checkbox"/> Aspirin
<input type="checkbox"/> <input type="checkbox"/> Asthma/Hay Fever	<input type="checkbox"/> <input type="checkbox"/> Heart Trouble	<input type="checkbox"/> <input type="checkbox"/> Pregnant	<input type="checkbox"/> <input type="checkbox"/> Codeine
<input type="checkbox"/> <input type="checkbox"/> Blood Pressure/High	<input type="checkbox"/> <input type="checkbox"/> Pace Maker	<input type="checkbox"/> <input type="checkbox"/> Rheu Fever/Murmur	<input type="checkbox"/> <input type="checkbox"/> Local Anesthesia
<input type="checkbox"/> <input type="checkbox"/> Blood Pressure/Low	<input type="checkbox"/> <input type="checkbox"/> Hepatitis/Liver Disease	<input type="checkbox"/> <input type="checkbox"/> Stroke	<input type="checkbox"/> <input type="checkbox"/> Penicillin
<input type="checkbox"/> <input type="checkbox"/> Cancer/Tx/X-Ray	<input type="checkbox"/> <input type="checkbox"/> Herpes Virus	<input type="checkbox"/> <input type="checkbox"/> TB/Lung Disease	<input type="checkbox"/> <input type="checkbox"/> Sedatives/Tranquiliz.
<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> HIV Positive/AIDS	<input type="checkbox"/> <input type="checkbox"/> TMJ/Clicking Joint	<input type="checkbox"/> <input type="checkbox"/> Premedicate
<input type="checkbox"/> <input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> <input type="checkbox"/> Joint Replacement	<input type="checkbox"/> <input type="checkbox"/> Venereal Disease	<input type="checkbox"/> <input type="checkbox"/> Medical Alert
<input type="checkbox"/> <input type="checkbox"/> _____	<input type="checkbox"/> <input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> <input type="checkbox"/> _____	<input type="checkbox"/> <input type="checkbox"/> _____
<input type="checkbox"/> <input type="checkbox"/> Cardiovascular disease (heart attack, angina, coronary insufficiency, coronary occlusion, arteriosclerosis)			
<input type="checkbox"/> <input type="checkbox"/> Are you taking birth control pills?			
<input type="checkbox"/> <input type="checkbox"/> Do you have persistent cough?			
<input type="checkbox"/> <input type="checkbox"/> Do you have unexplained fever or chills?			
<input type="checkbox"/> <input type="checkbox"/> Do you have night sweats?			
<input type="checkbox"/> <input type="checkbox"/> Do you have unexplained fatigue?			
My doctor is _____ Phone # _____			
Taking Medications <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, _____			
Allergic to Medications <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, _____			
Prior Unpleasant Dental Treatment _____			

General Health Comments _____			

Medical history updated on _____			

Please be aware that you are responsible for any balance that is not paid by your insurance company.

The above information is true and complete to the best of my knowledge. I agree to pay my co-payment at the time services are rendered.

The Doctor is not responsible for completion of treatment if I consistently fail to keep scheduled appointments.

I certify that I have read and understand the above, I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature _____ Date _____

Office Manager _____ Date _____

Dentist Signature _____ Date _____