

SPENCER B. WAGNER, D.M.D, P.C.

(801) 426-6255

Note: The information in this form is necessary for our records. It is considered strictly confidential.
Please complete all parts. Please print in ink.

NAME _____ AGE _____
LAST FIRST MIDDLE

ADDRESS _____
STREET CITY STATE ZIP CODE

PHONE _____ BIRTHDATE _____
RESIDENCE BUSINESS

IF MINOR, PARENTS NAME _____

ADDRESS IF DIFFERENT _____

S.S. # OF PATIENT _____

MEDICAL HISTORY

General health (please check): Excellent Good Fair Poor

Last complete physical? _____ Findings? _____

Physician _____ Phone _____

Are you taking any medication now? Yes No Medication Name/Purpose: _____

Have you ever been treated for: (You Must Answer Yes or No)

Heart disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Heart murmur	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Rheumatic fever	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Jaundice	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Abnormal blood pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Asthma or hay fever	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Ulcers	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Sinus trouble	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Tuberculosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Hepatitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Arthritis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Epilepsy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Stroke	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Anemia	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Glaucoma	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Congenital heart lesions	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Serious accident	Yes <input type="checkbox"/>	No <input type="checkbox"/>
VD (Syphilis, Gonorrhea)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	AIDS	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Herpes	Yes <input type="checkbox"/>	No <input type="checkbox"/>			

Have you ever been treated (other than diagnostic) with x-ray? Yes No

Are you allergic to: Penicillin Codeine Local injected anesthetics Latex

Other allergies to Medications _____

Are you subject to prolonged bleeding? Yes No

Are you subject to fainting spells Yes No

(Women) Are you pregnant? Yes No How long? _____

COMMENTS:

DENTAL HISTORY

Date of last dental visit? _____ Doctor _____

Are you dissatisfied with the appearance of your teeth? Yes No

Have you had orthodontic treatment? Yes No

Do you clench or grind your teeth during the day or night? Yes No

Have you ever had pain in your jaw or your face (in and about your ears)? Yes No

Do you have an unpleasant odor, or taste, in your mouth? Yes No

Do your gums bleed when brushing? Yes No

Have you had gum disease or pyorrhea? Yes No

Have you had periodontal surgery? Yes No

Is your mouth or teeth sensitive to: Pressure Yes No Cold Yes No

Hot Yes No

Does food catch between your teeth? Yes No

Please add anything you feel is important for the doctor to know _____

Indicate any disease, condition, or problem not listed above

EMERGENCY PERSON _____ EMERGENCY # _____

PERMIT FOR TREATMENT

This is to certify that I, undersigned, consent to the performing of the dental and oral surgical procedures agreed to be necessary or advisable, including the use of local anesthetics as indicated, and I will assume responsibility for fees associated with those procedures.

The above information is accurate to the best of my knowledge.

Patient's (Parent's) Signature _____ Date _____

Interviewer's Signature _____