DENTAL HEALTH HISTORY (Confidential)

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Reason for Today's Visit	Date of last dental c	are
Former Dentist	Date of last dental X	-rays
Address		
Check (🗸) if you have had problems v	with any of the following	
Bad breath	Grinding teeth	Sensitivity to hot
Bleeding gums	Loose teeth or broken fillings	Sensitivity to sweets
Clicking or popping jaw	Periodontal treatment	Sensitivity when biting

Food collection between teeth

Sensitivity to cold

Sores or growths in your mouth

How often do you floss? _____

How often do you brush?_____

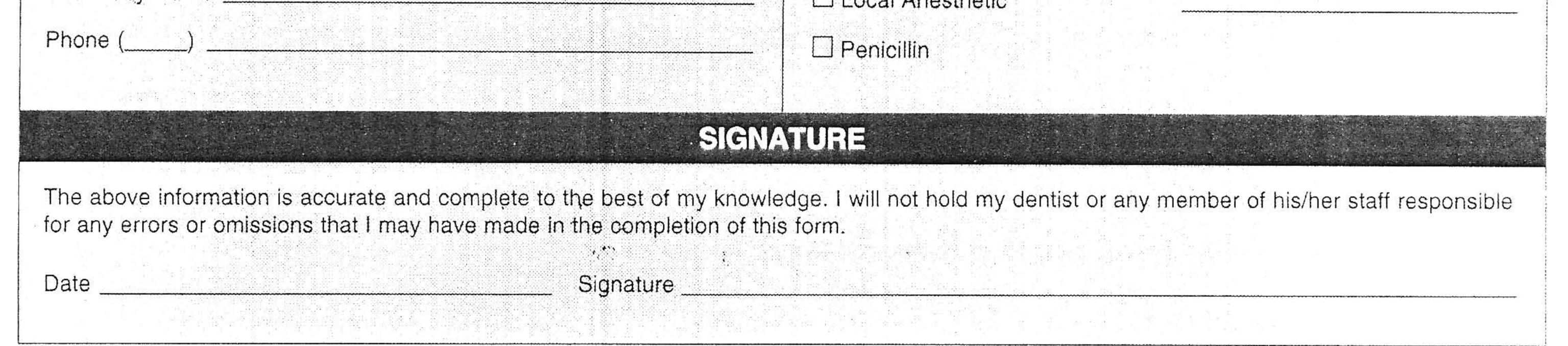
MEDICAL HISTORY

Physician's Name Date of Last Visit Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine.) 🗌 Yes 🗌 No Have you had any serious illnesses or operations? If yes, describe Have you ever had a blood transfusion? 🗌 Yes 🗌 No If yes, give approximate date(s) ______ (Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No Check (✓) if you have or have had any of the following: Anemia
 Cortisone Treatments Hepatitis Scarlet Fever Arthritis, Rheumatism Cough, Persistent High Blood Pressure Shortness of Breath Artificial Heart Valves HIV/AIDS Cough up Blood Skin Rash Artificial Joints Diabetes Jaw Pain Stroke Epilepsy ☐ Kidney Disease Swelling of Feet or Ankles Asthma □ Fainting Back Problems Liver Disease Thyroid Problems Blood Disease Glaucoma Mitral Valve Prolapse Tobacco Habit Headaches Pacemaker L Cancer Chemical Dependency Tuberculosis □ Radiation Treatment Heart Murmur Chemotherapy Heart Problems Ulcer Respiratory Disease Hemophilia Venereal Disease

Circulatory Problems

Rheumatic Fever

MEDICATIONS	ALLERGIES
List medications you are currently taking:	🗆 Aspirín
	Barbiturates (Sleeping pills) * 🛛 Latex
	Codeine
Pharmacy Name	Clocal Anesthetic



DENTAL REGISTRATION AND HISTORY

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(PLEASE PRINT)

KIRK W. WESTERVELT, D.M.D. 1146 W. State Route 89A, Ste. A

Sedona, AZ 86336

Telephone: (928) 204-2062

Date	Home Phone ()	Cell Pho	ne ()
	PATI	ENT INFORMATIO	DN	
Name Last Name	First Name	Middle Initial	SS/HIC/Patient	ID #
			E-mail	
City			State	_ Zip
Sex 🗌 M 🗌 F Age	Birthdate			Single Minor

		Divorceu Parmereu ior years
Patient Employer/School		Occupation
Employer/School Address		Employer/School Phone ()
Whom may we thank for referring you?		1
In case of emergency who should be notified?		Phone ()
	PRIMARY INSURAN	CE
Person Responsible for Account		
Last Name		First Name Middle Initial
Relation to Patient	Birthdate	Soc. Sec. #
Address (If different from patient's)		Phone ()
City		State Zip
Person Responsible Employed by		Occupation
Business Address		Business Phone ()
Insurance Company		
Contract #	Group #	Subscriber #
Names of other dependents covered under this plat	n	
	ADDITIONAL INSURA	NCE
Is patient covered by additional insurance? Yes	🗌 No	
Subscriber Name	Birthdate	Relation to Patient
Address (If different from patient's)		Phone ()
City		State Zip
Subscriber Employed by		Business Phone ()
Insurance Company		Soc. Sec. #
Contract #	Group #	Subscriber #
Names of other dependents covered under this plan	٦	

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with	and assign directly to
Name of Insu	irance Company(ies)
Dr all insurance benefits, if any, otherwis that I am financially responsible for all charges whether or not paid by insurance. I authorize the	se payable to me for services rendered. I understand e use of my signature on all insurance submissions.
The above-named doctor may use my health care information and may disclose such information their agents for the purpose of obtaining payment for services and determining insurance bene	efits or the benefits payable for related services. This
consent will end when my current treatment plan is completed or one year from the date signed	d below.
consent will end when my current treatment plan is completed or one year from the date signed	d below.
Signature of Patient, Parent, Guardian or Personal Representative	d below. Date

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