Welcome to the office of Dr. Gary Woodall, DDS, MAGD

Please supply the following information in order that we may better serve you

Name	**Date**	**Sex**
		Male____ Female ____
Address **City** **State** **Zip**		**Date of Birth**
		/ /
Home Phone **Work Phone** **Cell**		**Social Security Number**
		_ _

Occupation **Employer**	**How Long With Company?**
Work Address City **State** **Zip**	**E-Mail Address:**
Work Phone **Extension**	_____

Do you have dental insurance?
____Yes ____No

If yes, please present card at front desk.

Do you have secondary insurance?
____Yes ____No

If yes, company name:

Who is responsible for the payment of this account? ___Self ___Spouse ___Parent ___Other

Marital Status: ____Single ____Married ____Divorced ____Separated ____Widowed

Spouse Name: Address:

Phone: Date of Birth:

Social Security Number: Employer:

Work Address: How long with company?

Whom shall we contact in the event of an emergency?

Name Phone

Whom may we thank for referring you?

Name

Comments:

Medical History

Gary R. Woodall, D.D.S., M.A.G.D.
Cosmetic & Complete Family Dentistry

Patient Name: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions…

Are you under a physician's care now?	☐ Yes	☐ No	
Have you ever been hospitalized or had a major operation?	☐ Yes	☐ No	_____
Have you ever had a serious head or neck injury?	☐ Yes	☐ No	_____
Are you taking any medications, pills or drugs?	☐ Yes	☐ No	_____
Have you ever taken Fosamax, Boniva, Actonel or any Bisphosphonates?	☐ Yes	☐ No	
Do you take or have you taken Phen-Fen or Redux?	☐ Yes	☐ No	
Are you on a special diet?	☐ Yes	☐ No	
Do you use tobacco?	☐ Yes	☐ No	
Do you use controlled substances?	☐ Yes	☐ No	

Women: Are you ____ Pregnant/Trying to get pregnant? ____ Nursing? ____ Taking oral contraceptives?

Are you allergic to any of the following? Yes _____ No _____; If yes, please list… ___Aspirin ___Penicillin

___Codeine ___Acrylic ___Metal ___Latex ___Local Anesthetics ___Sulfa Drugs Other_____

Do you have or have you had any of the following? If yes, please darken circle...

○ Aids/HIV Positive	○ Chest Pains	○ Frequent Headaches	○ Irregular Heartbeat	○ Scarlet Fever
○ Alzheimer's Disease	○ Cold Sores/Fever Blisters	○ Genital Herpes	○ Kidney Problems	○ Shingles
○ Anaphylaxis	○ Congenital Heart Disorder	○ Glaucoma	○ Leukemia	○ Sickle Cell Disease
○ Anemia	○ Convulsions	○ Hay Fever	○ Liver Disease	○ Sinus Trouble
○ Angina	○ Cortisone Medication	○ Heart Attack/Failure	○ Low Blood Pressure	○ Spina Bifida
○ Arthritis/Gout	○ Diabetes	○ Heart Murmur	○ Lung Disease	○ Stomach/Intestinal Disease
○ Artificial Heart Valve	○ Drug Addiction	○ Heart Pace Maker	○ Mitral Valve Prolapse	○ Stroke
○ Artificial Joint	○ Easily Winded	○ Heart Trouble/Disease	○ Osteoporosis	○ Swelling of the Limbs
○ Asthma	○ Emphysema	○ Hemophilia	○ Pain in Jaw Joints	○ Thyroid Disease
○ Blood Disease	○ Epilepsy or Seizures	○ Hepatitis A,B, or C	○ Parathyroid Disease	○ Tonsillitis
○ Blood Transfusion	○ Excessive Bleeding	○ Herpes	○ Psychiatric Care	○ Tuberculosis
○ Breathing Problem	○ Excessive Thirst	○ High Blood Pressure	○ Radiation Treatments	○ Tumors or Growths
○ Bruise Easily	○ Fainting Spells/Dizziness	○ High Cholesterol	○ Recent Weight Loss	○ Ulcers
○ Cancer	○ Frequent Cough	○ Hives or Rash	○ Renal Dialysis	○ Venereal Disease
○ Chemotherapy	○ Frequent Diarrhea	○ Hypoglycemia	○ Rheumatic Fever	○ Yellow Jaundice

Have you ever had any serious illnesses not listed above? ____No ____Yes _____

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of patient, parent or guardian _____ **Date** _____