

**Earl E. Woeltje DDS MAGD**

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**WE WOULD LIKE TO GET TO KNOW YOU BETTER!**

There are two pages please answer them to the best of your knowledge.

Name \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Sex \_\_\_\_\_

Email (For our office only) \_\_\_\_\_

Birth Date \_\_\_\_\_ Social Security Number \_\_\_\_\_

Parent's Names \_\_\_\_\_

Guardian's Name (If Applicable) \_\_\_\_\_

Guardian's Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_ Work Phone Number \_\_\_\_\_ Ext \_\_\_\_\_

Whom May We Thank For Referring You to Our Office?  
\_\_\_\_\_

**Who will be responsible for payment of this account?**  
\_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Social Security Number \_\_\_\_\_

Employer's Address \_\_\_\_\_

Work Phone Number \_\_\_\_\_ Extension \_\_\_\_\_

Relationship to Patient: Parent \_\_\_\_\_ Spouse \_\_\_\_\_ Other \_\_\_\_\_

If you also have dental insurance please ask for our Insurance Policy so we can enter your information accurately

MEDICAL HISTORY

- 1. Who is your physician: \_\_\_\_\_
- 2. Please list: all medications you are presently taking (i.e. Birth control, aspirin):  
\_\_\_\_\_
- 3. Please list all medications you are allergic or had an Adverse reaction to: \_\_\_\_\_
- 4. Have you ever had major surgeries? .....Yes No  
Operations and dates \_\_\_\_\_
- 5. Do you have any heart problems such as but not limited to the following (please circle): .....Yes No  

Mitral Valve Prolapse	Heart Attack
Stroke	Heart Murmur
Valve replacement	Rheumatic Fever
Other	
- 6. Have you ever had breathing difficulty such as asthma, emphysema, pneumonia, tuberculosis? .....Yes No
- 7. Do you have a history of excessive bleeding .....Yes No
- 8. Do you have high blood pressure .....Yes No
- 9. Are you currently taking aspirin?.....Yes No  
Do you regularly take aspirin?.....Yes No
- 10. Are you subject to fainting, dizziness, nervous disorders, convulsions, or epilepsy?.....Yes No
- 11. Are there any limitations to your physical activity .....Yes No
- 12. Do you use tobacco products? .....Yes No  
What Kind \_\_\_\_\_ How Much \_\_\_\_\_
- 13. Do you have sinus troubles .....Yes No
- 14. Are you or could you be pregnant? .....Yes No
- 15. Have you ever tested HIV positive .....Yes No
- 16. Circle any of the conditions below that you may have or have had in the past:  

Anemia	Hepatitis	Diabetes
Jaundice	Glaucoma	Kidney Disease
Arthritis		
- 17. My Height \_\_\_\_\_ My Weight \_\_\_\_\_

I understand that the information I provide on this form is essential to determine my overall health needs. I have read and understand each question; I have answered all of them truthfully and to the best of my knowledge.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Patient, Parent, or Guardian

