



Wesley M. Ferguson DMD

Kenneth Ramsey DDS, FAGD **General Dentistry**

405 Academy Rd., Starkville, MS 39759 (662) 323-2876

SECTION I:

Date: _____

Name: Dr. Mr. Mrs. Ms _____

Home Phone: _____ Cell Phone: _____

Home Address: _____ City/State/Zip _____

Email: _____ Preferred method of contact: _____ phone _____ email _____

Employer _____ Business Phone: _____

Social Security #: _____ Date of Birth: _____

Person Responsible for Account: _____

Relationship to Patient: _____ Soc. Sec. #: _____ Date of Birth: _____

Address (if different from above): _____

City/State/Zip: _____

Employer: _____ Business Phone: _____

Insurance Company: _____

Group #: _____ Subscriber #: _____ Phone: _____

SECTION II:

How did you hear about us?

_____ Website _____ Yellow Pages _____ Other: _____

_____ Friend/Relative, whom may we thank? _____

_____ Other Dentist/Specialist, whom may we thank? _____

SECTION III:

Reason for today's visit: _____

Date of last dental care: _____ Date of last dental x-rays: _____

Please check if you have had problems with any of the following:

_____ Bad Breath _____ Grinding or Clenching Teeth _____ Sensitivity when Biting

_____ Bleeding Gums _____ Loose Teeth or Broken Fillings _____ Sensitivity to Sweets

_____ Clicking or Popping Jaw _____ Periodontal Treatment _____ Sores or Growths in Mouth

_____ Food Collection b/t teeth _____ Sensitivity to Hot _____

_____ History of Fever Blisters _____ Sensitivity to Cold _____

SECTION IV:

1. Are you in good health? Y N

2. Are you currently under a physician's care? Y N

If so, what for? _____

Treating Physician's Name: _____ Phone Number: _____

3. Have you had any serious illnesses, operations, or hospitalizations? Y N

If so, describe and give approximate dates: _____

4. Have you ever had intravenous sedation or general anesthesia? Y N

Were there any adverse effects? Y N

5. Do you generally tolerate dental treatment well? Y N

6. Have you ever been told by a dentist or physician that you needed to take antibiotics before dental procedures? Y N

7. DO YOU HAVE OR HAVE EVER HAD:

A. Heart disease that was detected at birth? Y N

B. Rheumatic fever or Rheumatic heart disease? Y N

C. Cardiovascular disease (chest pain, heart trouble, heart attack, coronary artery disease, high blood pressure, stroke, palpitations, heart surgery, angioplasty, pacemaker)? Y N

D. Lung disease (asthma, emphysema, chronic cough, bronchitis, pneumonia, TB, shortness of breath, severe cough)? Y N

SECTION IV CONT'D:

- E. Neurologic disorders (seizure, epilepsy, fainting, dizziness, nervous disorder)? Y N
- F. Blood disease (bleeding disorder, anemia, blood transfusion, do you bruise easily)? Y N
- G. Liver disease (jaundice, hepatitis)? Y N
- H. Diabetes? Y N
- I. Thyroid disease (hypothyroidism, tumor)? Y N
- J. Arthritis? (which joints? Y N
- K. Stomach ulcers or Intestine problems? Y N
- L. Frequent or recurring mouth sores? Y N
- M. Implants/artificial joints anywhere in your body (heart valve, hip, knee)? Y N
- N. Radiation (X-ray treatment for cancer) in head and neck region? Y N
- O. Noises in jaw joint, pain near ear when chewing, do you grind or clench teeth? Y N
- P. Sinus or nasal problems? Y N
- Q. Any disease, drug or transplant operation that has depressed the immune system? Y N
- R. Recurrent infections of any kind? Y N
- 8. ARE YOU TAKING OR USING ANY OF THE FOLLOWING:

 - A. Antibiotics? Y N
 - B. Anticoagulants (blood thinners)? Y N
 - C. Thyroid medications? Y N
 - D. Antihistamines, decongestants? Y N
 - E. High blood pressure or heart medications? Y N
 - F. Steroids? Y N
 - G. Tranquilizers, antidepressants? Y N
 - H. Stomach or GI medications (antacids, etc.)? Y N
 - I. Cholesterol reducing drugs? Y N
 - J. Aspirin, ibuprofen, NSAIDS or anti-inflammatory drugs, narcotics, opioids, or other pain relievers? Y N
 - K. Any of the bisphosphonate class of drugs (Boniva, Fosamax, etc.)? Y N
 - N. Marijuana, cocaine or other recreational drugs? Y N
 - O. Any other regular medications, pills, supplements or drugs? Y N

- PLEASE LIST ALL CURRENT MEDICATIONS HERE: _____

- 9. ARE YOU ALLERGIC TO OR HAD A BAD REACTION FROM:

 - A. Local anesthetic (Novocain-like drugs)? Y N
 - B. Penicillin, Amoxicillin, Cephalosporins? Y N
 - C. Other antibiotics? Y N
 - D. Barbiturates, sedatives? Y N
 - E. Aspirin, ibuprofen, NSAIDS, or other pain relievers? Y N
 - F. Codeine or other narcotics or opioids? Y N
 - G. Latex? Y N
 - H. Other allergies or reactions? Y N

- PLEASE LIST: _____

- 10. Do you use alcohol? How much per day? _____ Y N
- 11. Do you smoke? If so, what product? _____ How many per day? _____ For how long? _____ Y N
- 12. Do you use spit tobacco? For how long? _____ Y N
- 13. Are you, or have you been, in a drug or alcohol recovery program? Y N
- 14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? Y N
- 15. Do you wish to talk to the doctor privately about anything? Y N
- 16. Any additional comments? _____
- 17. **WOMEN**

 - A. Are you taking birth control pills? Y N
 - B. Are you pregnant, trying to become pregnant, or any chance you might be pregnant? Y N
 - C. Are you BREAST FEEDING? Y N
 - D. Are you taking hormonal replacement? Y N

I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I understand that I am financially responsible for all charges whether or not paid by insurance, as well as, any finance charges, collection, attorney, and court fees used to collect on my account. By signing below, I also acknowledge that I have received copies of the office policies regarding dental insurance and cancelled/broken appointments. The above information is accurate and complete to the best of my knowledge. I will not hold Dr. Ferguson or Dr. Ramsey or any member of their staff responsible for errors or omissions that I may have made in the completion of this form.

Date: _____ Signature: _____