New Waverly Place Dentistry

Dr. Yiming Zhang, DDS & Dr. Brodie S. Jenkins, DDS
540 New Waverly Place, Suite 301 Cary, NC 27518
Phone: (919)-233-1978 Fax: (919)-865-0268

PATIENT INFORMATION:

Name: _____ _____ _____
Last First Middle Initial
Address: _____
City: _____ State: _____ Zip Code: _____
Home: (____) _____-_____ Cell: (_____) _____-_____ Email: _____
Preferred method of contact (please circle): Home Cell Email Occupation: _____
Sex: ☐Male ☐Female Age: _____ Birthdate: _____/_____/_____ SSN#: _____
☐Married ☐Widowed ☐Single ☐Minor ☐Separated ☐Divorced ☐Partnered
Patient Employer/School: _____ Work Phone: (____) ____-_____
In case of **Emergency** please contact: _____ Phone: (____) _____-_____

DENTAL PRIMARY INSURANCE:

Person Responsible for Account: _____
Last First Middle Initial
Relation to Patient: _____Birthdate: _____/_____/_____ SSN#:_____
Address (If different from patient): _____
City: _____ State: _____ Zip Code: _____ Phone: (____) _____-_____
Employer of Person Responsible: _____
Insurance Company: _____ Phone: (____) _____-_____
Insurance Address: _____ City: _____ State: _____ Zip Code: _____
Group #:_____ Subscriber #:_____

DENTAL HISTORY:

Reason for Today's Visit: _____ Date of Last Visit: _____
Former Dentist: _____ Date of Last X-Rays: _____
Address: _____ Did you have x-rays emailed to our office? _____
Whom may we thank for referring you? _____

Check if you have had problems with any of the following:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Clicking or Popping Jaw
- ☐ Grinding Teeth
- ☐ Loose Teeth or Broken Fillings
- ☐ Food Collection Between Teeth
- ☐ Periodontal Treatment (Gum Disease)
- ☐ Sores or Growths in Mouth

Sensitivity to:

- ☐ Hot
- ☐ Sweets
- ☐ Biting
- ☐ Cold

How often do you floss? _____ How often do you brush? _____
If you could change anything about your smile, what would it be?
_____

MEDICAL HISTORY:

Physician's Name: _____ Date of Last Visit: _____

☐ Yes ☐ No Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include any combination of Ionimin, Adipex, Fastin, Pondimin (fenfluramine), and Redux (dexfenfluramine)?

☐ Yes ☐ No Have you had any serious illnesses or operations? If yes, describe and list years:
_____

☐ Yes ☐ No Have you ever had a blood transfusion? If yes, when: _____

☐ Yes ☐ No Do you drink Soda or Energy Drinks?

☐ Yes ☐ No Do you drink alcoholic beverages? How often? _____

☐ Yes ☐ No Do you use tobacco (smoking, snuff, and chew)? Years: _____

If you answered yes to the above question, how interested are you in stopping? ☐ Very ☐ Somewhat ☐ Not Interested

Please turn the page to continue →

PATIENT NAME_____

Check if you have or have had any of the following:

- ☐ Acid Reflux/Heart Burn
- ☐ Alzheimer/Dementia
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Valves
- ☐ Artificial Joints: _____
- ☐ Asthma
- ☐ Autism Spectrum Disorder
- ☐ Autoimmune Disease
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes: Type I or II
- ☐ Eating Disorder
- ☐ Epilepsy
- ☐ Fainting/Dizziness
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis: Type _____
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental Health Disorders: Depression/Anxiety/_____
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Physical Handicap
- ☐ Radiation Treatment
- ☐ Respiratory Disease/COPD
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Sexually Transmitted Disease: Specify _____
- ☐ Shortness of Breath
- ☐ Sleep Disorder
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Treatment for Bone Density
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ other _____

WOMEN ONLY

- ☐ Yes ☐ No Are you pregnant? If so, number of weeks: _____
- ☐ Yes ☐ No Are you nursing?
- ☐ Yes ☐ No Are you taking birth control or hormonal replacement

ALLERGIES

Are you **allergic** to or have had a **reaction** to any of the following: If yes, specify type of reaction.

Local Anesthetics …….. ☐ Yes ☐ No _____
Aspirin …….. ☐ Yes ☐ No _____
Antibiotics …… ☐ Yes ☐ No _____
Barbiturates, sedatives, or sleeping pills….. ☐ Yes ☐ No _____
Sulfa drugs…….. ☐ Yes ☐ No _____
Codeine or other narcotics (opioids)..... ☐ Yes ☐ No _____
Metals …… ☐ Yes ☐ No _____
Latex (Rubber)…… ☐ Yes ☐ No _____
Hay fever/ seasonal …….. ☐ Yes ☐ No _____
Animals …… ☐ Yes ☐ No _____
Food …… ☐ Yes ☐ No _____
Other …… ☐ Yes ☐ No _____

MEDICATIONS (including vitamins, natural or herbal preparations, or dietary supplements):

Name	Dosage Taken	How Often

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and their staff will rely on this information for treating me.

_____ _____
SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF A MINOR **DATE**

_____ _____
SIGNATURE OF DENTIST **DATE**