Welcome to Walnut Street Dental Associates

Bradley J. Bullard, D.D.S.   Alicia A. Bullard, D.D.S.

In order to care for your dental needs, please provide the following confidential information.

Patient Information

(Last) Name	First Middle Initial	SSN #
Preferred Name	Birthdate	Male/Female
Address	City	State Zip
Home Phone	Cell Phone	Work Phone

Check Appropriate Box: ☐ *Minor* ☐ *Single* ☐ *Married* ☐ *Widowed* ☐ *Divorced*

Billing Address if different than above

Name	Address	City
State Zip	Home Phone	Cell Phone
Are you a college student? Yes ☐ No☐	College	City

Person to contact in case of emergency____ Phone______________________________

Whom may we thank for referring you?____

Is another member of your family a patient here?____________________________________

Account Information

Name of person responsible for this account_______________________________________ Relationship to Patient__________________

Employer	
SSN #	Birthdate

Spouse's Name

Employer	
SSN #	Birthdate

Dental Insurance Information

Primary Carrier		
Address	Member ID #	Group #
Employer	Employee	Birthdate
Secondary Carrier		
Address	Member ID #	Group #
Employer	Employee	Birthdate

How would you like us to confirm your dental appointments?

☐Home# ☐Cell# ☐Work## ☐email ____

Turn over for back side

Medical/Dental History

What prompted you to seek dental care?____

When was your last dental visit?__________________________________

Y/N Are you having pain or discomfort at this time?

Y/N Have you ever had a bad experience in a dental office?

Medical Information

Y/N Have you been under the care of a medical doctor in the last two years?

Y/N Have you been hospitalized in the last two years?

Date of last Physical_________________________

Physicians Name____

Address____ Phone___________________________

Y/N Are you currently taking any prescription medications?

Please List____

Y/N Are you currently taking any non-prescription medications or supplements?

Please List____

Are you allergic to any medications? Please List____

Y/N Are you allergic to latex?

Y/N Have you ever taken an antibiotic before dental procedures?

<u>Circle</u> any of the following which you have had or have at present:

Heart Disease
Heart Attack or Failure
Angina
High Blood Pressure
Heart Murmur/Mitral Valve Prolpse
Congenital Heart Problems
Artificial Heart Valve
Heart Surgery
Heart Pacemaker
Anemia
Stroke
Bleeding/Clotting Conditions
Blood Transfusion
Bruise Easily
Leukemia
Asthma
Emphysema/COPD
Persistent Cough

Tuberculosis
Allergies
Sinus Trouble
Sleep Apnea/Snoring
Diabetes (Type I/Type II)
Liver Disease
Hepatitis (A, B, C)
Thyroid Disease
Kidney Disease
Ulcers
Digestive Issues
Auto immune Disease
Arthritis
Artificial Joint (Hip, Knee, etc.)
Cortisone Medicine
HIV/Aids
Fainting or Dizzy Spells
Epilepsy or Seizures

Nervousness/Anxiety
Dementia/Alzheimer"s
Psychiatric Treatment
Chemical Dependency
Eating Disorder
Cancer or Tumor
Chemotherapy/Radiation Therapy
Glaucoma
Cold Sores/ Fever Blisters
Other:____________________________________
____
____

Y/N Do you use tobacco?

Y/N Are you on a special diet?

Y/N Have you gained or lost more than 10 pounds in the last year?

Y/N Do your ankles swell during the day?

Y/N Do you wake up short of breath?

Y/N Are you ever short of breath or have pain in your chest?

Women Only

Y/N Are you pregnant or nursing?

Signature_____________________________ **Print Name**______________________ **Date**______________________