1104 Kenilworth Dr
Suite 102
Towson, MD 21204

MELODY D. WARD, D.D.S, M.S.
PERIODONTICS AND IMPLANT SURGERY

251 Najoles Dr
Suite D
Millersville, MD 21208

Welcome Patients!

Thank you for choosing our office. Please fill out this form to the best of your ability.

Date:_____ ☐ Married ☐ Single ☐ Partnered ☐ Divorced ☐ Widowed

Name:_____ ☐ M ☐ F Birthdate:____/_____/_____ Age:___ SSN:_____

Home Address:_____

Hm # (_____)_____ Cell # (_____)_____ Wk# (_____)_____ Preferred #: Home Cell Work

Email Address:_____ Best time to reach you?_____

Whom may we thank for referring you?_____ Other family seen by us?_____

Employer:_____ How long there?_____ Occupation:_____

Employer's Address:_____

In the event of an emergency, whom should we contact?

His/Her Name:_____ Relation:_____ Cell # (or best contact)_____

Person responsible for Account, if other than yourself

Name:_____ Relation:_____ SSN:_____

Employer:_____ Wk #: (_____)_____ Hm # (_____)_____

Billing Address:_____

Insurance Information

Insurance Co. Name:_____ Ins. Co. Ph #: (_____)_____ Group#:_____

Insurance Policy ID #:_____ Insurance Co. Address:_____

Insured's Name:_____ Relation:_____ Insured's Birthdate:____/____/_____

Insured's SSN:_____ Insured's Employer:_____ Employer Ph #: (_____)_____

Dental Coverage ☐Yes ☐No Medical Coverage ☐Yes ☐No Orthodontic Coverage ☐Yes ☐No

P: (410) 583-5214 F: (410) 583-2272 wardperio@gmail.com

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Name:_____ DOB:_____ Email:_____

1. Are you having any dental pain or discomfort at this time?..... Yes No
2. Have you been a patient in the hospital during the past two years? ..... Yes No
3. Have you been under the care of a medical doctor during the past two years?..... Yes No

   Physician's Name_____ Date of Last Visit: _____

   Address_____ Telephone_____

4. Are you currently taking any medications, drugs or pills?.....Yes No

   If yes, please list:_____

5. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance?.....Yes No

   If yes, please list:_____

Please mark which of the following you have had or presently have:

Acid Reflux/GERD	_____	Drug Addiction	_____	Liver disease	_____
Anemia	_____	Emphysema	_____	Mental disorders	_____
Arthritis	_____	Epilepsy/Seizures	_____	Mitral Valve Prolapse	_____
Artificial Heart Valve	_____	Excessive Bleeding	_____	Multiple Sclerosis	_____
Artificial Joints	_____	Glaucoma	_____	Nervous Disorders	_____
Asthma	_____	High Blood Pressure	_____	Respiratory Problems	_____
Blood Disorder	_____	Head Injuries	_____	Rheumatic Fever	_____
Blood Transfusion	_____	Heart Failure	_____	Rheumatism	_____
Bruise Easily	_____	Heart Murmur	_____	Sickle Cell Disease	_____
Cancer/Tumor	_____	Heart Pacemaker	_____	Sinus Problems	_____
Chemo/Radiation	_____	Heart Surgery	_____	Stroke	_____
Chest Pain	_____	Hemophilia	_____	Thyroid Problems	_____
Chronic Cough	_____	Hepatitis	_____	Tuberculosis	_____
Cortisone Medicine	_____	High Cholesterol	_____	Venereal Disease	_____
Cosmetic Surgery	_____	HIV/AIDS	_____	Other: _____	
Diabetes	_____	Jaundice	_____		
Dizziness/Fainting	_____	Kidney Disease	_____		

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6. Do you have pain in your jaw joints?.....Yes No

7. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired?.....Yes No

8. Do your ankles swell during the day?.....Yes No

9. Do you snore when you sleep?.....Yes No

10. Do you experience persistent dry mouth?.....Yes No

11. Do you ever wake up from sleep and feel short of breath?.....Yes No

12. Have you ever taken a bisphosphonate or similar medication, eg, Fosamax, Actonel, Boniva,?.....Yes No

13. Are you on a special diet?.....Yes No

14. Do you have or have you had any disease, condition or problem not listed?.....Yes No
If yes, please list:_____

For Women Only: Are you pregnant? Yes, what month?_____ No Are you nursing? Yes No Are you taking birth control pills? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature_____ Date:_____

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