Austin
DENTAL CARE

Glen M. Wainwright, DDS

Welcome to the practice of Dr. Glen Wainwright, DDS. We believe there's only one way to practice dentistry: with compassion, clear communication and clinical excellence. It's our responsibility to help you plan for a future of good dental health while taking time to answer your questions and concerns. So if you need additional information, don't hesitate to ask. We want to keep you smiling!

Name (Last) (First) (Middle) / / Date of Birth M F Sex S M D W Marital Status Social Security Number

Home Address (Street) (City (State) (Zip Code)

Home Phone Business Phone Other Phone

Email Address Cellular Phone Pager #

If full-time Student:
Name of Employer Occupation Name of School Grade

If under 18, Legal Guardian Address Phone

Dental Insurance Co./ Employer Name Group # Ins. Co. Phone Number

Policy Holder's Name & Relation to Patient Policy Holder's SSN Policy Holder's Date of Birth

In case of Emergency, call Home Phone Work Phone

How did you hear of Dr. Wainwright?

General health (please check): EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐ Name of physician_

Physician's address _____telephone number _____date of last physical

Are you pregnant? Yes ☐ No ☐ If yes, expected delivery date:

Do you smoke? Yes ☐ No ☐ If yes, how much?

Are you allergic to any substances

and/or medications?…….. Yes ☐ No ☐ If yes, please list:

Are you taking any medication now? Yes ☐ No ☐ If yes, names of medications and problems for which they are taken:

Medication 1) Taken for 3)
2) _____ 4)_____ _____

Have you ever had (please check-mark appropriate boxes): Joint Replacement…… Yes ☐ No ☐

Heart disease		Yes ☐	No ☐	Cancer		Yes ☐	No ☐
Rheumatic fever		Yes ☐	No ☐	Mitral valve prolapse		Yes ☐	No ☐
Abnormal blood pressure	High ☐	Low ☐	No ☐	Night sweats		Yes ☐	No ☐
Ulcers		Yes ☐	No ☐	Heart murmur		Yes ☐	No ☐
Tuberculosis or lung disease		Yes ☐	No ☐	Jaundice		Yes ☐	No ☐
Diabetes		Yes ☐	No ☐	Drastic weight loss		Yes ☐	No ☐
Epilepsy		Yes ☐	No ☐	Hayfever		Yes ☐	No ☐
Anemia		Yes ☐	No ☐	Sinus trouble		Yes ☐	No ☐
Congenital heart lesions		Yes ☐	No ☐	Hepatitis		Yes ☐	No ☐
Arthritis		Yes ☐	No ☐	X-ray treatments for cancer		Yes ☐	No ☐
Lymph node enlargement (swollen glands)		Yes ☐	No ☐	Glaucoma		Yes ☐	No ☐
Asthma		Yes ☐	No ☐	Taking Bisphosphonates		Yes ☐	No ☐
AIDS		Yes ☐	No ☐	Stroke		Yes ☐	No ☐
Prolonged bleeding		Yes ☐	No ☐	Fainting spells		Yes ☐	No ☐
Excessive urination and/or thirst		Yes ☐	No ☐	Swollen ankles		Yes ☐	No ☐

If you have entered "yes" to any of the above, please explain:

What are your hobbies? Special Interests?