



Welcome

Patient Registration and Dental History

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Patient Information

Patient Name _____ Date of Birth _____
 Social Security # _____ Marital Status _____
 Patient Address _____ City, State, Zip _____
 Home Phone _____ Work Phone _____
 Email Address _____ Cell Phone _____
 What is the best way to confirm your dental appointment? _____
 Patient's Employer _____ Present Position _____
 Spouse's Employer _____ Present Position _____
 Will the fees for our services be offset by dental insurance? Yes/No _____
 Subscriber Name _____ Relationship to patient _____
 Name of Dental Insurance Company _____
 Identification Number _____ Group Number _____
 Who may we thank for referring you to our office? _____

Dental History

Are you aware of any dental problems at this time? _____
 How long has it been since you have been to a dentist? _____
 What was done then? _____
 How often did you visit a dentist before then? _____
 Previous Dentist's Name _____ Address _____
 Have you had any problems or complications with previous dental treatment? _____

Have you ever had any of the following dental procedures done? If so, please explain.

Gum Treatments or Periodontal Surgery? Yes/No _____
 Orthodontic Treatment? Yes/No _____
 Oral Surgery? Yes/No _____
 Endodontic Treatment? Yes/No _____
 Have you ever whitened your teeth? Yes/No _____ Are you interested in whitening? _____
 Have you lost any teeth or have any teeth been removed? Yes/No Why? _____

Do you or have you ever experienced any of the following?

_____ Hot/Cold Sensitivity _____ Clench or grind your teeth
 _____ Unpleasant Breath _____ Difficulty opening or closing
 _____ Bleeding Gums _____ Jaw clicks, pops, or locks
 _____ Tender Gums _____ Frequently get cavities
 _____ Food gets caught _____ Build up a lot of plaque/calculus
 _____ Pain or soreness in you face or by your ear
 How often do you brush? _____ How often do you floss? _____
 What other products/rinses do you use? _____
 Do you usually have teeth numbed for dental work? Yes/No _____
 If you could change anything about your teeth or smile, what would that be? _____
 Are you planning to keep your remaining teeth your whole lifetime? Yes/No _____
 Is there anything we can do to make your dental appointment more comfortable? _____

I certify that the above information is complete and accurate.

Patient/Guardian Signature _____ Date: _____
 Dentist's Initials _____ Date: _____

Complete Reverse Side

Medical History

Patient Name _____ Birthdate _____

WELCOME, Please take the time to complete this form with your current medical information. You, and your families medical history will influence your susceptibility to certain dental conditions. The following information should be as complete and accurate as possible as we use it to select the most appropriate dental care for you. Please inform us of any changes to your medical history in the future.

Physician's Name _____ Physician's Address _____

Date of your last medical physical: _____ Are you currently under the care of a physician? Y / N

Why? _____

Please check and/or circle any of the following conditions that you have or have had in the past:

- | | |
|---|--|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Herpes/Cold Sores/Shingles |
| <input type="checkbox"/> Anemia/Blood disorders | <input type="checkbox"/> Kidney/Liver Problems |
| <input type="checkbox"/> Any heart problems | <input type="checkbox"/> Mental/Emotional Disorders |
| <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Nervous Problems |
| <input type="checkbox"/> Artificial Heart Valve Implant/Pacemaker | <input type="checkbox"/> Organ Transplant, Type: _____ |
| <input type="checkbox"/> Asthma/Hay fever/Difficulty Breathing | <input type="checkbox"/> Osteopenia or Osteoporosis |
| <input type="checkbox"/> Blood Pressure Problems: High / Low | <input type="checkbox"/> Prosthetic Joint Replacement, Date: _____ |
| <input type="checkbox"/> Cancer, Type: _____ | <input type="checkbox"/> Radiation or Chemotherapy, Why: _____ |
| <input type="checkbox"/> Diabetes: Type 1 or Type 2 | <input type="checkbox"/> Rheumatic Fever |
| Controlled or Uncontrolled? By Medication or Diet? | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Fainting or Dizzy Spells | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Frequent Headaches, shoulder or neck aches | <input type="checkbox"/> Tested Positive for HIV |
| <input type="checkbox"/> Glaucoma or light sensitivity | <input type="checkbox"/> Thyroid: Hypothyroid / Hyperthyroid |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Hepatitis, Type: _____ | <input type="checkbox"/> Venereal Disease |

Have you taken the prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products? Y / N if Yes, what: _____

Have you ever had a disease condition, serious illness or major surgery not listed above? Y / N If yes, please explain: _____

Is there a family history of Diabetes, Heart Disease, Oral Cancer, or Periodontal Disease? Y / N If yes, please explain: _____

Would you describe your stress level as high, average, or low? Circle one.

Do you smoke, chew, use snuff, or any other forms of tobacco? Y / N Circle those that apply.

How long? _____ How much? _____ Are you interested in quitting? _____

Do you consume alcoholic beverages or use recreational drugs? Y / N Circle those that apply.

Please list any medications you are currently taking,
Include prescription and non-prescription.

List any health related substance you take routinely.
Include any vitamins, supplements, or natural products.

If female, please answer the following:

Do you use Birth Control medications Y / N

Are you pregnant? Y / N If Yes, # of weeks _____

Are you nursing? Y / N

Yes / No List All Allergies

- | | | |
|--------------------------|--------------------------|--------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Aspirin |
| <input type="checkbox"/> | <input type="checkbox"/> | Codeine |
| <input type="checkbox"/> | <input type="checkbox"/> | Dental Anesthetics |
| <input type="checkbox"/> | <input type="checkbox"/> | Erythromycin |
| <input type="checkbox"/> | <input type="checkbox"/> | Jewelry or metals |
| <input type="checkbox"/> | <input type="checkbox"/> | Latex |
| <input type="checkbox"/> | <input type="checkbox"/> | Penicillin |
| <input type="checkbox"/> | <input type="checkbox"/> | Sulfa |

Other: _____

I certify that the above information is complete and accurate.

Patient/Guardian Signature _____ Date: _____

Dentist's Initials _____ Date: _____