Patient Information

Patient Name____ Date:__________
Last, First MI (Preferred Name)

Social Security#____________ Birth Date:__________ *Age :*___ Gender:_____ Marital Status: ______________

Phone (Home):______________ (Work): _______________ (Cell):______________ Email: _________________

Address: ____
Street Apartment # City State Zip Code

Employer:_______________ Occupation: ______________ Years at this job:______Drivers Lic#: ____

In case of Emergency Contact: ____
Name Relationship Home Phone Work/Cell Phone

Whom may we thank for referring you to our practice?_______________________________________

Medical History

Are you currently under a physicians care? ☐ Yes ☐ No If so, for what reason?__________________________

Physicians Information ____(___)__________
Dr's Name Address City State Zip Phone

Please mark any of the following you may have had, or have at present:

- ☐ Rheumatic Fever
- ☐ Heart Murmur
- ☐ Congenital Heart Disease
- ☐ Artificial Heart Valve
- ☐ Pacemaker
- ☐ High/Low Blood Pressure
- ☐ Heart Attack or Heart Disease
- ☐ Blood thinning treatment
- ☐ HIV or AIDS
- ☐ Hepatitis <u>or</u> Liver Disease
- ☐ Venereal Disease
- ☐ Inner Ear Disorders or Surgery
- ☐ Artificial Joint
- ☐ Surgical Prosthesis
- ☐ Ulcers/Stomach Problems
- ☐ Cancer or Related Treatment
- ☐ Kidney Trouble
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Scarlet Fever
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Arthritis/Rheumatism
- ☐ Stroke
- ☐ Epilepsy or seizures
- ☐ Fainting or dizzy spells
- ☐ Psychiatric treatment
- ☐ Leukemia
- ☐ Bruise Easily
- ☐ Asthma
- ☐ Hay Fever
- ☐ Emphysema
- ☐ Allergies or Hives
- ☐ Sinus trouble
- ☐ Cold sores or herpes
- ☐ Other:_________________

For Women Only-

Are you pregnant? ☐ Yes ☐ No
Due Date: _____________
Are you nursing? ☐ Yes ☐ No
Do you take birth control?☐ Yes ☐ No

Do you or have you used:

- ☐Tobacco
- ☐Alcohol
- ☐Illegal Iv Drugs
- ☐Other: ___________________

Have you ever been requested to take antibiotics or other medications before a dental appt? ☐ Yes ☐ No
Is there anything else we should know about your health that is not covered on this form? ☐ Yes ☐ No
Would you like to speak with the doctor privately about any matter? ☐ Yes ☐ No

Medications

List all medications and dietary supplements you have taken in the last 3 months. Include dosage and reason for taking the medication________________________

Allergies

Mark all medications or health care related substances to which you have experienced an allergic or adverse reaction:

☐ Penicillin ☐ Sulfa drugs ☐ Others____________
☐ Codeine ☐ Epinephrine ________________
☐ Latex ☐ Local Anesthetics ☐ None

I certify that the above medical information is complete and accurate.

______________________________________ Date ______________________ Date
Signature of patient, parent or guardian Dentist Signature

Dental History

Reason for seeking dental care at this time _______________________Date of last dental visit ________ Reason?_______________

Date of last X-rays ____________Former Dentist _______________________City/State __________________ Phone #____________

How often do you: <u>Brush</u> 1 / 2 / 3 times per day / week <u>Floss</u> 0 / 1 / 2 / 3 times per day / week / month

How do you feel about dental treatment? ☐ **Relaxed** ☐ **A little uneasy** ☐ **Tense** ☐ **Anxious** ☐ **Very Anxious**

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

- ☐ Periodontal / Gum Disease
- ☐ Perio Cleanings / Treatment
- ☐ Sensitive or bleeding gums
- ☐ Grinding or clenching
- ☐ Swelling or lumps in mouth
- ☐ Loose teeth
- ☐ Cold sores
- ☐ Bad breath
- ☐ Swollen glands
- ☐ Aching or sensitive teeth
- ☐ Areas of food traps
- ☐ Difficulty opening wide
- ☐ Clicking or popping in jaw
- ☐ Jaw pain or tiredness
- ☐ Orthodontic treatment
- ☐ Unfavorable dental experience
- ☐ Growths or lesion in your mouth
- ☐ Broken or missing teeth / fillings
- ☐ Dry mouth
- ☐ Other ___________________

If you could change your smile, what would you change?

- ☐ Remove unsightly fillings
- ☐ Straighten teeth
- ☐ Change shape of teeth
- ☐ Replace missing teeth
- ☐ Close gaps between teeth
- ☐ Make teeth same color
- ☐ Whitening
- ☐ Other ___________________

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the patient's guardian if patient is a minor ☐ the person responsible for payment

Name: ____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ________________

Social Security #: __________________ Birth Date: _________ Employer: ________________________________

Phone (Home): ________________ (Work): ________________Ext: _____ (Cell): ________________________

Address: ____
Street Apartment # City State Zip Code

Insurance Information

Primary Dental Insurance:

Insurance Plan Name and Address: ____ Group #: _______________

____

Insurance Company Phone Number Electronic Payor ID#___________

Name of Subscriber: ____Is subscriber a patient? ☐ Yes ☐ No
Last First MI

Subscriber's Birth Date: _____________ Social Security #: ____________________ ID #: ____________________

Subscriber's Address: ____
Street City State Zip Code

Subscriber's Employer Name: ___________________________________Employer Phone: ___________________

Employer Address: ____
Street City State Zip Code

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other ____________________

Secondary Dental Insurance Information:

Insurance Plan Name and Address:____________________________Group #: ___

Insurance Company Phone Number:____________________________________Electronic Payor ID#___________

Name of Subscriber: ____Is subscriber a patient? ☐ Yes ☐ No
Last First MI

Subscriber's Birth Date: _____________ Social Security #:____________________ ID #: ___________________

Subscriber's Address: ____
Street City State Zip Code

Subscriber's Employer Name: ___________________________________Employer Phone: ___________________

Address: ____
Street City State Zip Code

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other ____________________

Consent

I, the undersigned, hereby authorize the Doctor to take radiographs, study models, photographs, or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent that the Doctor employ any such assistance as he/she deems appropriate.

I further authorize the release of any information, including the diagnosis, radiographs and records of any treatments or examinations rendered to my insurance company, consulting professionals or others that may request my records.

I certify that the above insurance information, if applicable, is correct and in force. I am aware that it is my responsibility to read and understand my own dental insurance policy, including benefits, limitations and exclusions. I understand that filing of insurance claims is my responsibility and may be provided as a service to me by Wikle Family Dental, and that any agreement for dental coverage is between my insurance company and myself. I understand that an estimated portion is due at the time of service and is estimated according to expected coverage, which may not be disclosed nor guaranteed by my insurance company. I understand my portion may be more if my insurance company does not pay the anticipated amount. I also understand that services are rendered independent of insurance reimbursement.

I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collection fees. I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins. I agree that credit bureau reports may be obtained, where appropriate.

____ Date: ________________ Relationship to Patient: ____________________
Signature of patient, parent, guardian or responsible party