PATIENT INFORMATION and HEALTH HISTORY

Drs. Larson, Martyn and Hafner LLP

www.mequonfamilydentistry.com

LAST NAME ______________________ TITLE ________ FIRST NAME ______________________

MIDDLE NAME ______________________ MARITAL STATUS ____ (SPOUSE'S NAME) ______________________

ADDRESS ______________________ CITY ______________________ STATE ____ ZIP __________

HOME PHONE ______________ WORK PHONE ______________ CELL PHONE ______________

BEST WAY TO CONTACT YOU: ☐ home ☐ work ☐ cell ☐ email ______________________

EMPLOYED BY ______________________ S.S.N. ______________________ BIRTH DATE __________

PHYSICIAN/MD ______________________ Date of last physical exam ______ REFERRED BY ______________________

DENTAL INSURANCE YES ___ NO ___ **(If yes, please fill out *INSURANCE INFORMATION FORM*)**

Have you been hospitalized in the last 5 years? .... YES ___ NO ___

If yes, for what reason ____

Are you currently undergoing any medical treatment? .... YES ___ NO ___

If yes, please explain ____

Please list any medications you are currently taking (oral or IV) ____

____

Are you allergic or have had a reaction to: PENICILLIN yes ___ no ___ ASPIRIN yes ___ no ___ LATEX yes ___ no ___

LOCAL ANESTHETIC yes ___ no ___ OTHER MEDICATIONS ______________________________

Do you smoke? YES ___ NO ___ If yes, how much? ______________________________

(Women) Are you pregnant? YES ___ NO ___ If yes, DUE DATE ______________________________

Have you ever had any of the following?

	YES	NO		YES	NO		YES	NO
ABNORMAL BLEEDING	___	___	EPILEPSY	___	___	OSTEOPOROSIS	___	___
AIDS	___	___	FAINTING	___	___	PACEMAKER	___	___
ALLERGIES	___	___	GLAUCOMA	___	___	RADIATION THERAPY	___	___
ANEMIA	___	___	HEART DISEASE	___	___	RHEUMATIC FEVER	___	___
ARTHRITIS	___	___	HEART MURMUR	___	___	SCARLET FEVER	___	___
ASTHMA	___	___	HEPATITIS	___	___	STEROIDS (CORTISONE)	___	___
BONE DISEASE	___	___	HIGH BLOOD PRESSURE	___	___	T.B.	___	___
CANCER	___	___	JOINT REPLACEMENT	___	___	THYROID DISEASE	___	___
DIABETES	___	___	KIDNEY DISEASE	___	___	ULCER DISEASE	___	___
EMPHYSEMA	___	___	LIVER DISEASE	___	___	VENEREAL DISEASE	___	___

Is there anything else we should know about your health that we have not covered on this form? ______________________

____

RESPONSIBLE PARTY FOR PATIENT:

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. I consent to the dentist's use and disclosure of my (or my child's) records to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment and payment. My consent and disclosure of records shall be effective until I revoke it in writing. I agree to be responsible for service not paid by my insurance or dental care payer.

NAME and ADDRESS ____

SIGNATURE ______________________________________ DATE ______________

DENTAL HISTORY

PURPOSE OF INITIAL VISIT ______________________________

HOW LONG SINCE YOUR LAST DENTAL VISIT? ____________ X-RAYS TAKEN ______________

WHAT WAS DONE AT THAT TIME? ______________________________

PREVIOUS DENTIST'S NAME ______________________________

(Address) ______________________________ (Phone) ______________

Do you clench or grind your teeth? YES ___ NO ___ Do you have any pain in or near your ears? YES ___ NO ___

Have you been diagnosed with TMJ disorder? YES ___ NO ___

Are any of your teeth sensitive to: Hot _____ Cold _____ Sweets _____ Pressure _____

Do your gums hurt or bleed? YES ___ NO ___ Have you ever had gum treatment or surgery? YES ___ NO ___

If yes, please explain ______________________________

How often do you brush your teeth? ______________ How often do you floss? ______________

Have you ever had any problems or complications with previous dental treatment? YES ___ NO ___

If yes, please explain ______________________________

Are you aware of any congenitally missing teeth? ______________________________

Are you happy with the appearance of your teeth? ______________________________

Have you had any unpleasant dental experiences or anything about dentistry that you strongly dislike? ______________

____

Do you ever have cold sores? YES ___ NO ___ Canker sores? YES ___ NO ___

Any additional remarks? ______________________________

DATE	SERVICE RENDERED	FEE