

PATIENT INFORMATION and HEALTH HISTORY

Drs Larson, Hafner and Fink

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 ☐ 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 Vape? YES / NO Chew Tobacco? YES / NO If yes, how much? _____

(Women) Are you pregnant? YES / NO If yes, DUE DATE _____ Are you nursing? _____

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	___	___	TUBERCULOSIS (TB)	___	___
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 _____

(IF DIFFERENT THAN ABOVE)

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? _____

For office use only
