N48 W14170 Hampton Avenue
Menomonee Falls, WI 53051
262-781-8416

PATIENT INFORMATION

FIRST NAME	MIDDLE NAME	LAST NAME

PATIENT LIKES TO BE CALLED	PREFERRED TITLE MR. ( ) MRS. ( ) MS. ( ) DR. ( ) ATTY. ( ) JDG. ( ) FR. ( ) SR. ( ) REV. ( )

ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE	BIRTHDATE	AGE	MALE	FEMALE	MARRIED ( ) SINGLE ( ) DIVORCED ( ) WIDOWED ( )

CELL PHONE	E-MAIL ADDRESS

OCCUPATION	EMPLOYER	BUSINESS PHONE	MAY WE CALL YOU AT WORK? YES ( ) NO ( )

IF STUDENT – NAME OF SCHOOL	GRADE	SOCIAL SECURITY #

IF CHILD, MOTHER'S NAME	MOTHER'S OCCUPATION	FATHER'S NAME	FATHER'S OCCUPATION

ACCOUNT INFORMATION

PERSON RESPONSIBLE FOR ACCOUNT	RELATIONSHIP TO PATIENT

RESPONSIBLE PARTY'S ADDRESS	CITY	STATE	ZIP CODE

RESPONSIBLE PARTY'S HOME PHONE	WORK PHONE	OCCUPATION	PLACE OF EMPLOYMENT

RESPONSIBLE PARTY'S BUSINESS ADDRESS	CITY	STATE	ZIP CODE

SPOUSE INFORMATION

SPOUSE (IF APPLICABLE) FIRST NAME	LAST NAME

OCCUPATION	EMPLOYER	BUSINESS PHONE

GENERAL INFORMATION

REFERRED BY	WHICH DOCTOR DO YOU PREFER TO SEE?

PERSON TO CONTACT IN CASE OF EMERGENCY	RELATIONSHIP TO PATIENT	HOME PHONE

CLOSEST RELATIVE NOT LIVING WITH YOU	HOME PHONE	BUSINESS PHONE

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE CO.

ADDRESS	CITY	STATE	ZIP CODE	PHONE NUMBER

GROUP NUMBER	EFFECTIVE DATE

POLICY HOLDER'S NAME	BIRTHDATE

EMPLOYER	EMPLOYER'S ADDRESS

POLICY HOLDER'S SOCIAL SECURITY #	FAMILY COVERAGE	SINGLE COVERAGE

SECONDARY INSURANCE CO.

ADDRESS	CITY	STATE	ZIP CODE	PHONE NUMBER

GROUP NUMBER	EFFECTIVE DATE

POLICY HOLDER'S NAME	BIRTHDATE

EMPLOYER	EMPLOYER'S ADDRESS

POLICY HOLDER'S SOCIAL SECURITY #	FAMILY COVERAGE	SINGLE COVERAGE

ASSIGNMENT OF BENEFITS/SIGNATURE ON FILE

I hereby assign all dental benefits to which I am entitled to Generations Family Dental Care, LLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

SIGNATURE **DATE**

GENERATIONS
Family Dental

N48 W14170 Hampton Avenue
Menomonee Falls, WI 53051
262-781-8416

DENTAL HISTORY

Patient Name

What is the reason for your visit today? ____________________

____

Date of Last Dental Visit ________ **Last Dental Cleaning** ________ **Last Full Mouth X-Rays** ________

What was done at your last dental visit? ____________________

____

Previous Dentist's Name ____________________

Address ____________________ State ________ Zip ________

Telephone ____________________

How often do you have dental examinations? ____________________

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

What other dental aids do you use? (Interplak, toothpick, etc.) ____________________

Do you have any dental problems now? **Yes** **No**

If yes, please describe: ____________________

Are any of your teeth sensitive to:

Hot or cold? Yes No
Sweets? Yes No
Biting or chewing? Yes No
Have you noticed any mouth odors or bad tastes? Yes No
Do you frequently get cold sores, blisters or any other oral lesions? Yes No

Do your gums bleed or hurt? Yes No
Have your parents experienced gum disease or tooth loss? Yes No
Have you noticed any loose teeth or change in your bite? Yes No
Does food tend to become caught in between your teeth? Yes No
If yes, where ____________________

Do you:

Clench or grind your teeth while awake or asleep? Yes No
Bite your lips or cheeks regularly? Yes No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) Yes No
Have tired jaws, especially in the morning? Yes No
Smoke/chew tobacco? Yes No

Have you ever had:

Orthodontic treatment? Yes No
Oral surgery? Yes No
Gum treatment? Yes No
Your bite adjusted? Yes No
A bite plate or mouth guard? Yes No
A serious injury to the mouth or head? Yes No
If so, please describe, including cause ________

____

Have you experienced:

Clicking or popping of the jaw? Yes No
Pain? (joint, ear, side of face) Yes No
Difficulty in opening or closing the mouth? Yes No
Difficulty in chewing on either side of the mouth? Yes No
Headaches, neckaches or shoulder aches? Yes No
Sore muscles (neck, shoulders)? Yes No

Are you satisfied with your teeth's appearance? Yes No

Do you feel nervous about having dental treatment? Yes No
If so, what is your biggest concern?

____

Have you ever had an upsetting dental experience? Yes No
If yes, please describe ____________________

____

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe ____________________

____

____

(Please complete other side)

MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years? .... Yes No

   If yes, for what? ____________________

2. Physician's Name ____________________ Phone ____________________

   Address ____________________ City __________ Zip __________

3. Have you taken any medication or drugs during the past two years? .... Yes No

4. Are you taking any medication, drugs or pills now? .... Yes No

   If yes, please list name and dosage ____________________

5. Are you aware of having an allergic (or adverse) reaction to any medication or substance? .... Yes No

   If yes, please list ____________________

6. Have you been a patient in the hospital during the past five years? .... Yes No

7. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Hepatitis A (infectious) B (serum)	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S.	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Contact Lenses	Yes	No	Cold Sores / Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Blood Transfusion	Yes	No
Artificial Valve	Yes	No	Chronic Cough	Yes	No	Hemophilia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Cortisone Medicine	Yes	No	Latex Sensitivity	Yes	No	Yellow Jaundice	Yes	No
Swollen Ankles	Yes	No	Allergies or Hives	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No	Nervous/Anxious	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Psychiatric/Psychological Care	Yes	No

8. Do you use more than two pillows to sleep? .... Yes No

9. Have you lost or gained more than 10 pounds in the past year? .... Yes No

10. Do you have or have you had any disease, condition, or problem not listed? .... Yes No

    If yes, please list ____________________

11. **Women.** Are you: **Pregnant?** Yes__ No__ Months______ **Nursing?** Yes__ No__ Taking birth control pills? Yes__ No__

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature ____________________ **Date** __________

History Review

Doctor Signature ____________________ Date __________