



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



CHILDREN'S DENTAL AND MEDICAL HEALTH HISTORY

CHILD'S NAME _____		DATE OF BIRTH _____
CHILD LIKES TO BE CALLED _____	SCHOOL _____	GRADE _____
MOTHER'S NAME _____	FATHER'S NAME _____	

MEDICAL HISTORY

1. Name of Physician _____ Is the Dr. a Pediatrician? YES NO
Address _____ City _____ State _____ Zip _____
2. Has your child ever been hospitalized, had major operations or a serious illness? YES NO
If so, what and when? _____
3. Are you aware of your child having an allergic (or adverse) reaction to any medication or substance? YES NO
If so, what? _____
4. Is your child taking any drugs or medications? YES NO
If so, what? _____ What amount? _____
5. Has your child ever had abnormal bleeding after a cut or tooth extraction? YES NO
6. Is your child subject to nervous disorders? YES NO
fainting? YES NO
dizziness? YES NO
7. Has your child had any of the following:

	YES	NO	AGE		YES	NO	AGE		YES	NO	AGE
A) RHEUMATIC FEVER	<input type="checkbox"/>	<input type="checkbox"/>	_____	G) WHOOPING COUGH	<input type="checkbox"/>	<input type="checkbox"/>	_____	M) ANEMIA	<input type="checkbox"/>	<input type="checkbox"/>	_____
B) DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	_____	H) HEART TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>	_____	N) HEART MURMUR	<input type="checkbox"/>	<input type="checkbox"/>	_____
C) MEASLES	<input type="checkbox"/>	<input type="checkbox"/>	_____	I) KIDNEY DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	_____	O) HEPATITIS	<input type="checkbox"/>	<input type="checkbox"/>	_____
D) SCARLET FEVER	<input type="checkbox"/>	<input type="checkbox"/>	_____	J) LUNG DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	_____	P) AIDS	<input type="checkbox"/>	<input type="checkbox"/>	_____
E) CHICKEN POX	<input type="checkbox"/>	<input type="checkbox"/>	_____	K) ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	_____	Q) EPILEPSY	<input type="checkbox"/>	<input type="checkbox"/>	_____
F) MUMPS	<input type="checkbox"/>	<input type="checkbox"/>	_____	L) X-RAY THERAPY	<input type="checkbox"/>	<input type="checkbox"/>	_____	R) ABNORMAL BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	_____

DENTAL HISTORY

1. Is this your child's first visit to a dentist? YES NO
2. If not, has your child ever received a local anesthetic? YES NO
3. Has your child ever received sealants? YES NO
4. Have any cavities been noted in the past? YES NO
5. Were any teeth (baby or permanent) removed by extraction? YES NO
6. Have there been any injuries to your child's teeth, such as falls, blows, chips, etc.? YES NO
If so, (would you) explain? _____
7. Fluoride History:
 - a) Do you live in a fluoridated area? YES NO
 - b) Do you give your child any form of fluoride tablets? YES NO
 - c) Has a dentist ever applied any fluoride to your child's teeth? YES NO
8. Has your child ever had a bad medical or dental experience? YES NO
If so, explain? _____
9. Has anyone in the family, including parents, had orthodontics? YES NO
If so, who? _____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____

SIGNATURE OF DENTIST _____ DATE _____

