GENERATIONS
Family Dental

37 Hickory Drive
Random Lake, WI 53075
920.994.4367

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 | ID # | 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-Random Lake, 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**

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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

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___
12. Do you smoke/chew tobacco? ..... 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_____