

**GETTING TO KNOW YOU AS OUR PATIENT**

PATIENT NAME	SOCIAL SECURITY NUMBER	HOME PHONE (      )
Home Address	City, State, Zip	Birthdate /      /
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	<input type="checkbox"/> M <input type="checkbox"/> F	

<b>Responsible Party</b>		
NAME	SOCIAL SECURITY NUMBER	HOME PHONE (      )
Home Address	City, State, Zip	Birthdate /      /
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	Relationship to Patient	
Responsible Party's Employer	Occupation	Work Phone (      )
Business Address	City	State                  Zip
<b>Spouse's Name</b>		Birthdate /      /
Spouse's Employer	Spouse's Occupation	Spouse's Work Phone (      )
Spouse's Business Address	City	State                  Zip

**In the event of an emergency, please contact:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
 Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**How did you hear about our Office?**  
(check only one)

Who selected this Office?     Self     Spouse     Parent     Employer

Where did you find the phone number to this Office? \_\_\_\_\_

Referred by a friend     Yellow Pages     Relative     Insurance Plan     TV/Radio Ad     Newspaper Ad

Other \_\_\_\_\_

If you were referred, whom may we thank for referring you? \_\_\_\_\_

**CONSENT**

I will answer all health questions on this form to the best of my knowledge. \_\_\_\_\_  
(initial here)

**TERMS AND CONDITIONS**

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits or another dentist.

I authorize and consent to the taking of photographs before, during, and after treatment. I further give permission for the use of those photographs for the purpose of research and education.

I understand that I am responsible for all costs of dental treatment.

I hereby authorize payment of insurance benefits directly to the dentist or dental group.

I attest that the above information is complete and accurate.

MAC Dental does not accept any patients with insurance through the State of Wisconsin (such as Badger Care, Medical Assistance, Title 19, Forward, etc.). By signing this form, I am stating that I am not covered under any state dental plan.

Signed \_\_\_\_\_ Date \_\_\_\_\_

**There may be a charge for any missed appointments or appointments not cancelled 24 hours before the appointment time.**

## PATIENT'S DENTAL HEALTH

Why have you come in to see us today? (e.g. pain, check-up, etc.) \_\_\_\_\_

Previous Dentist \_\_\_\_\_ Last Visit \_\_\_\_\_ Date of last cleaning \_\_\_\_\_

Reason for changing dentists: \_\_\_\_\_

What problems have you had with past dental treatment? \_\_\_\_\_

Are you nervous about seeing a dentist?  Yes  No If Yes, please tell us why: \_\_\_\_\_

How often do you brush? \_\_\_\_\_ Do you floss?  Yes  No If Yes, how often? \_\_\_\_\_

(please circle each)

Y N I clench or grind my teeth during the day or while sleeping.	Y N My gums feel tender or swollen.
Y N My gums bleed while brushing or flossing.	Y N I have problems eating.
Y N I like my smile.	Y N I have had orthodontics.
Y N I prefer tooth-colored fillings.	Y N I have had a facial or jaw injury.
Y N I avoid brushing part of my mouth due to pain.	Y N I want my teeth straight.
Y N I want my teeth whiter.	

What are your dental priorities? (e.g.: dental health, financial considerations, etc.) \_\_\_\_\_

\_\_\_\_\_

## PATIENT'S MEDICAL HISTORY

I consider my health to be (please check one)  Excellent  Good  Fair  Poor

Are you under a physician's care now?  Yes  No If YES, please explain: \_\_\_\_\_

\_\_\_\_\_

Have you ever been hospitalized or had a major operation?  Yes  No If YES, please explain: \_\_\_\_\_

\_\_\_\_\_

Have you ever had a serious head or neck injury?  Yes  No If YES, please explain: \_\_\_\_\_

\_\_\_\_\_

Have you ever taken bone-loss drugs during cancer treatment?  Yes  No

Do you use tobacco?  Yes  No

Do you use controlled substances?  Yes  No

For Office Use Only:

Blood Pressure: \_\_\_\_\_

**WOMEN ONLY:** Are you  Pregnant/Trying to get pregnant?  Nursing?  Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin  Ibuprofen  Sulfa Drugs/Sulfites/Sulfides  Penicillin  Codeine  Latex, Metals, Plastics

Local Anesthetics (Novocaine)  Other – which ones? \_\_\_\_\_

Do you or have you had any of the following?

<input type="checkbox"/> AIDS/HIV Positive	<input type="checkbox"/> Cold Sores/Fever Blisters	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Congenital Heart Disorder	<input type="checkbox"/> Heart Attack/Failure	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Snoring
<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Spina Bifida
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cortisone Medicine	<input type="checkbox"/> Heart Pace Maker	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Stomach/Intestinal Disease
<input type="checkbox"/> Angina	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Trouble/Disease	<input type="checkbox"/> Organ Transplant	<input type="checkbox"/> Stroke
<input type="checkbox"/> Arthritis/Gout	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Swelling of Limbs
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Easily Winded	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Pain in Jaw Joints	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Artificial Joint	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Hepatitis B or C	<input type="checkbox"/> Parathyroid Disease	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> Herpes	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> Tumors or Growths
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Recent Weight Loss	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Breathing Problem	<input type="checkbox"/> Fainting Spells/Dizziness	<input type="checkbox"/> History of Osteoporosis	<input type="checkbox"/> Renal Dialysis	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Frequent Cough	<input type="checkbox"/> Hives or Rash	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Wear CPAP
<input type="checkbox"/> Cancer	<input type="checkbox"/> Frequent Diarrhea	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Rheumatism	<input type="checkbox"/> Yellow Jaundice
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Shingles	
<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Sickle Cell Disease	

Have you ever had any serious illness not listed above?  Yes  No If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Please list all medications you are currently taking:

Medicine _____	Condition _____
Medicine _____	Condition _____
Medicine _____	Condition _____
Medicine _____	Condition _____
Medicine _____	Condition _____