Mukwonago
Family Dentistry™

1210 Marsh View Drive • Mukwonago, Wisconsin 53149 • 262-363-4041

Michael F. Connor, D.D.S.
Thomas L. McKeever, D.D.S.
Byron L. Hawks, D.D.S.
Charles F. Vento, D.D.S.
Pamela A. McWilliams, D.D.S.

Patient Information (CONFIDENTIAL)

Date _____

Last Name _____ First Name _____ Middle Initial _____

Birthdate _____ Social Security # _____ Home Phone _____

Address _____

City _____ State _____ Zip _____ Cell Phone _____

Patient's Employer _____ Work Phone _____

Spouse/Parent's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

Responsible Party (IF DIFFERENT FROM ABOVE)

Name _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Birthdate _____

Employer _____ Work Phone _____ Soc. Sec. # _____

Is this person currently a patient in our office? ☐ Yes ☐ No

Dental Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthday _____ Soc. Sec. # _____ Date Employed _____

Name of Employer _____ Work Phone _____

Insurance Company _____ Group # _____ Policy/ ID # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

How Much is Your Deductible? _____ Max. Annual Benefit _____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthday _____ Soc. Sec. # _____ Date Employed _____

Employer _____ Work Phone _____

Insurance Company _____ Group # _____ Policy/ ID # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

How Much is Your Deductible? _____ Max. Annual Benefit _____

Patient Medical History

Health Conditions:

Y	N	Pregnant
Y	N	Cancer/Leukemia
Y	N	Have you had radiation of head/neck?
Y	N	Heart Condition/Heart Attack
Y	N	Heart Murmur
Y	N	Mitral Valve Prolapse
Y	N	Pacemaker
Y	N	Prosthetic Replacements: Shunt, Hip, Elbow, Knee, Other: _____
Y	N	Abnormal Bleeding
Y	N	Osteoporosis
Y	N	Radiation Therapy
Y	N	High Blood Pressure
Y	N	Low Blood Pressure
Y	N	Rheumatic Fever
Y	N	Respiratory Problems
Y	N	Diabetes
Y	N	Hepatitis/Jaundice
Y	N	HIV Positive
Y	N	AIDS
Y	N	Glaucoma
Y	N	Asthma
Y	N	Epilepsy/Seizures
Y	N	Stroke
Y	N	Thyroid Condition
Y	N	Tuberculosis
Y	N	Kidney Ailments
Y	N	Acid Reflux/GERD
Y	N	Fainting Spells
Y	N	Arthritis
Y	N	Cold Sores or Canker Sores today

Are You Allergic to:

Y	N	Local Anesthetics
Y	N	Penicillin or any other Antibiotics
Y	N	Sulfa Drugs
Y	N	Barbiturates/Pain Medication
Y	N	Sedatives
Y	N	Aspirin
Y	N	Any Metals
Y	N	Latex

Other: _____

_____

Y	N	Are you taking a blood thinner? (ex. aspirin, Plavix, Coumadin, Warfarin)
Y	N	Do you take a pre-medication?
Y	N	Do you take medication to treat osteoporosis or other bone disease? (ex. Fosamax, Actonel, Boniva, Zometa, Reclast)
Y	N	Do you smoke or chew tobacco?

List All Medications You Are Taking: _____

_____

_____

_____

_____

_____

Patient Dental History

Name of Previous Dentist and Location _____ Date of last exam_____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Do you feel pain in any of your teeth?	☐	☐
3. Do you have any sores or lumps in or near your mouth?	☐	☐
4. Have you ever experienced any problems with your jaw?	☐	☐
5. Do you clench or grind your teeth?	☐	☐
6. Have you ever had any prolonged bleeding following extractions?	☐	☐
7. Have you had any orthodontic treatment?	☐	☐
8. Do you like your smile?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I agree to be responsible for payments of all services rendered on my behalf or my dependents. I am aware that a 1% finance charge will be added to balances over 90 days old. I am aware that I will be charged $25 for missed appointments, or appointments cancelled with less than 24 hours notice. ***I understand that my dental insurance carrier may pay less than the actual bill of services.**

_____

Signature of patient (or parent of minor)