



Mukwonago Family Dentistry™

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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 _____

Birthdate _____ 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 _____

Birthdate _____ 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, Heart Valve
 Y N Do you take a pre-medication?
 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
 Y N Parkinson's Disease
 Y N Dementia/Alzheimer's
 Y N Multiple Sclerosis (MS)

- Y N Are you taking a blood thinner?
 (ex. aspirin, Plavix, Coumadin, Warfarin)
 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: _____

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: _____

Patient Dental History

Name of Previous Dentist and Location _____ Date of last exam _____

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

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 for missed appointments, or appointments cancelled with less than 24 hours notice. ***I have contacted my insurance company and they have advised me of my coverage at Mukwonago Family Dentistry.**

 Signature of patient (or parent of minor)