

# PERSONAL INFORMATION



## 1. ABOUT YOU

Date \_\_\_\_\_

Patient Name \_\_\_\_\_

I prefer to be addressed as \_\_\_\_\_

(please check)  Male  Female  Child  Single  Married  Widowed  
 Divorced  Domestic Partnered

Home Address \_\_\_\_\_

City, Zip \_\_\_\_\_

Cell No. \_\_\_\_\_

Home No. \_\_\_\_\_ Work No. \_\_\_\_\_ Ext. \_\_\_\_\_

May we contact you at this work phone?  Yes  No

Email address(es) \_\_\_\_\_

How would you prefer to be reminded of appointments?  E-mail or  
 Phone (indicate preferred number to call) \_\_\_\_\_

Date of Birth \_\_\_\_\_

Drivers License No. \_\_\_\_\_

(note, we cannot take checks from those who do not provide their Drivers License No.)

Employer \_\_\_\_\_

Occupation \_\_\_\_\_

Other family and household members at Peterson Family Dentistry \_\_\_\_\_

Check all the ways you have heard about us

- Previous Patient  Phone Book
- Peterson Website  Insurance Website  Milwaukee Moms Website
- Sussex Sun Ad  Sussex Chamber of Commerce  Flyer  Dr. Ostdick
- Pick N Save Shopping Carts  Metro Parent  Family Magazine
- Referral from another dentist/patient/staff

Referral's dentist/patient/staff Name \_\_\_\_\_

## 2. SPOUSE/EMERGENCY INFO

Spouse/Partner \_\_\_\_\_

Employer \_\_\_\_\_

Cell No. \_\_\_\_\_

Work No. \_\_\_\_\_ Ext. \_\_\_\_\_

Date of Birth \_\_\_\_\_

In the event of an emergency, is there someone other than a spouse you would like us to contact?

Name \_\_\_\_\_

Relation \_\_\_\_\_

Home No. \_\_\_\_\_

Cell No. \_\_\_\_\_

Work No. \_\_\_\_\_ Ext. \_\_\_\_\_

## 3. FINANCIAL INFO

If other than yourself, please list the person responsible for the account and their information below

Name \_\_\_\_\_

Social Security No. \_\_\_\_\_

Billing Address \_\_\_\_\_

Home No. \_\_\_\_\_

Work No. \_\_\_\_\_ Ext. \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Employer Name \_\_\_\_\_

## 4. INSURANCE INFO

Primary Dental Coverage Insurance Co. \_\_\_\_\_

Insured's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Social Security No. \_\_\_\_\_

Do you have Secondary Dental Insurance Coverage?

Yes  No

I authorize release of any information relating to claims filed by **Peterson Family Dentistry**.

Signature \_\_\_\_\_

I wish to assign benefits to **Peterson Family Dentistry** and understand that I am responsible for any co-payment and deductibles that my insurance does not cover.

Signature \_\_\_\_\_ Date \_\_\_\_\_

# DENTAL INFORMATION



## 1. MEETING PATIENT'S IMMEDIATE NEEDS

Patient Name \_\_\_\_\_

What brings you here today?  Check-up Time  Problem  Other (explain) \_\_\_\_\_

Why are you changing dental offices?  Insurance  Location  Didn't Like  
 Other (explain) \_\_\_\_\_

Do you have problems with your teeth now?  Yes  No  
If Yes (check)  Hot  Cold  Sweet  Food-Caught  Broken Tooth  Other

## 2. PAST DENTAL HISTORY

When was the last time you saw a dentist?  1st visit  6 mo.  1 yr.  2 yrs.  3+ yrs.

Former Dentist \_\_\_\_\_

Clinic-Location \_\_\_\_\_

Phone No. \_\_\_\_\_

Last Visit \_\_\_\_\_

What treatment did you receive?  Preventive  Basic Fillings  Major Restoration

Was that a comfortable experience?  Yes  No

Why? \_\_\_\_\_

Did you have any treatment that was recommended but not yet completed?  Yes  No

If yes \_\_\_\_\_

## 3. HOME CARE & PERIO HISTORY

What do you do at home to take care of your oral health?

Brush; How often \_\_\_\_\_  Floss; How often \_\_\_\_\_ Mouthwash  Yes  No

Any bleeding when you brush or floss your teeth?  Yes  No

Concerned about (check)  Bad Breath  Taste

Other (explain) \_\_\_\_\_

## 4. COSMETIC

Are you happy with your smile?  Yes  No

Anything you would like to change if you could?  Color  Shape  Position

Detail (if needed) \_\_\_\_\_

## 5. FEARS OR ANXIETIES

Is there anything you don't like about dental appointments?

Discomfort  Fee  Time Inconvenience  Afraid  Other (explain) \_\_\_\_\_

## 6. LIFETIME SMILE PLAN

The way we practice dentistry is something we call "Lifetime Smile Plan." What that means is that we provide you with enough education about the health of your mouth so that you can make choices for yourself. This allows you to save your teeth for the rest of your life, while being happy about the way they LOOK and FEEL.

We are going to teach you about what is HEALTHY and UNHEALTHY, and we will provide you with the alternatives to treating the unhealthy areas. We will inform you of the risks, advantages and disadvantages of treating or not treating your teeth as well. One of the alternatives will always be "TO DO NOTHING." We will always inform you of your costs and what you can expect from your insurance before you schedule your treatment, so there will never be any surprise.

Other Comments \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



# HEALTH INFORMATION

## 1. HEALTH HISTORY Today's Date \_\_\_\_\_

Patient Name \_\_\_\_\_

Patient Date of Birth \_\_\_\_\_

Personal Physician \_\_\_\_\_

Clinic-Location \_\_\_\_\_

Phone No. \_\_\_\_\_

Please list any medications you are currently taking (include over the counter medicines)

Medications	Reasons
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are you currently taking birth control pills?  Yes  No

Have you ever taken osteoporosis treatment drugs?  Yes  No

## 2. ALLERGIES

Please circle if you have any allergies to the following:

Amoxicillin	Aspirin	Erythromycin	Metals / Jewelry	Sulfa
Anesthetics	Codeine	Latex	Penicillin	Tetracycline

Other (explain) \_\_\_\_\_

(If any circled) please describe symptoms: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## 3. CONDITIONS

Please circle if you have ever had any of the following diseases or medical conditions.

- Alzheimer's / Memory Loss
- Anemia
- Anorexia / Bulimia
- Arthritis
- Artificial Joints (Date \_\_\_\_\_)
- Artificial Heart Valves
- Asthma / Hay Fever
- Blood Transfusions
- Cancer / Chemotherapy
- Cold Sores / Herpes
- Congenital Heart Defect
- Diabetes
- Difficulty Breathing
- Drug / Alcohol Abuse
- Emphysema
- Epilepsy / Seizures / Fainting
- Gastrointestinal Disorder / Acid Reflux
- Glaucoma (Narrow Angle)
- Headaches (Severe, Frequent)
- Hearing Impaired
- Heart Attack
- Heart Murmur
- Heart Surgery
- Hemophilia / Abnormal Bleeding
- Hepatitis A B C D
- High / Low Blood Pressure
- HIV / AIDS
- Liver Disease
- Kidney Problems
- Migraines
- Mitral Valve Prolapse
- Pacemaker
- Radiation Treatments
- Rheumatic / Scarlet Fever
- Shingles
- Smoking / Tobacco
- Sinus Problems
- Stents Placed in Heart (Date \_\_\_\_\_)
- Stroke
- Snoring / Sleep Apnea
- Thyroid problems
- Tuberculosis
- Tumor Growth
- Venereal Disease
- Other / Surgeries

Have you ever been told you need antibiotics before a dentist appointment?  Yes  No

Are you pregnant?  Yes  No

Are you currently nursing?  Yes  No

Would you like to speak privately with the Doctor about any problems?  
 Yes  No

I hereby certify that the information I have given here today is correct to the best of my knowledge and that payment is due in full at the time of treatment unless prior arrangements have been approved. Furthermore I understand that a 24 hour notice is required to change appointments.

Signature \_\_\_\_\_ Date \_\_\_\_\_