



2505 North Mayfair Road
Wauwatosa, Wisconsin 53226
414.258.2117

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				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, SC. 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



GENERATIONS
Family Dental

2505 North Mayfair Road
Wauwatosa, Wisconsin 53226
414.258.2117

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)

1. Have you been under the care of a medical doctor or have you been hospitalized 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 or provide staff with a copy of your medications list. _____

5. Are you aware of having an allergic (or adverse) reaction to any medication or substance? Yes No
If yes, please list _____
6. Are you taking Bisphosphonates, i.e.: Fosamax, Boniva, Zometa, Retinol, Aredia, Didronel, oral or IV? Yes No
7. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (please circle: (Surgery, Disease, Attack)) . . . Yes No Chest Pain Yes No Congenital Heart Disease Yes No Heart Murmur Yes No High Blood Pressure Yes No Mitral Valve Prolapse Yes No Artificial Valve Yes No Heart Pacemaker Yes No Rheumatic Fever Yes No Arthritis/Rheumatism, Yes No Cortisone Medicine Yes No Swollen Ankles Yes No Stroke Yes No Diet (Special/Restricted) Yes No Artificial Joints (hip, knee, etc.) Yes No Kidney Trouble Yes No	Ulcers Yes No Diabetes Yes No Thyroid Problems Yes No Glaucoma Yes No Contact Lenses Yes No Emphysema Yes No Chronic Cough Yes No Tuberculosis Yes No Asthma Yes No Latex Sensitivity Yes No Allergies or Hives please circle: (seasonal / other) Yes No Sinus Trouble Yes No Radiation Therapy Yes No Chemotherapy Yes No Tumors Yes No	Cancer (please specify) Yes No Hepatitis A (infectious), B (serum) Yes No Venereal Disease Yes No A.I.D.S/H.I.V. Positive Yes No Cold Sores / Fever Blisters Yes No Blood Transfusion Yes No Hemophilia Yes No Smoke/Chew Tobacco Yes No Bruise Easily Yes No Liver Disease Yes No Yellow Jaundice Yes No Neurological Disorders Yes No Epilepsy or Seizures Yes No Fainting or Dizzy Spells Yes No Nervous/Anxious Yes No Psychiatric/Psychological Care Yes No
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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 ___

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** _____