N48 W14170 Hampton Avenue
Menomonee Falls, WI 53051
262-781-8416

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 | SOCIAL SECURITY #

OCCUPATION | EMPLOYER | BUSINESS PHONE | MAY WE CALL YOU AT WORK? YES ( ) NO ( )

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 | ID # | 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 Care-Menomonee Falls, LLC. 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

CHILDREN'S DENTAL AND MEDICAL HEALTH HISTORY

CHILD'S NAME		DATE OF BIRTH
CHILD LIKES TO BE CALLED	SCHOOL	GRADE
MOTHER'S NAME	FATHER'S NAME	

MEDICAL HISTORY

1. Name of Physician _____ Is the Dr. a Pediatrician? YES NO
   Address _____ City_____ State_____ Zip_____
2. Has your child ever been hospitalized, had major operations or a serious illness? ..... YES NO
   If so, what and when? _____
3. Are you aware of your child having an allergic (or adverse) reaction to any medication or substance? ..... YES NO
   If so, what? _____
4. Is your child taking any drugs or medications? ..... YES NO
   Is so, what? _____ What amount?_____
5. Has your child ever had abnormal bleeding after a cut or tooth extraction? ..... YES NO
6. Is your child subject to nervous disorders? ..... YES NO
   fainting? ..... YES NO
   dizziness? ..... YES NO
7. Has your child had any of the following:

	YES	NO	AGE		YES	NO	AGE		YES	NO	AGE
A) RHEUMATIC FEVER	❑	❑	_____	G) WHOOPING COUGH	❑	❑	_____	M) ANEMIA	❑	❑	_____
B) DIABETES	❑	❑	_____	H) HEART TROUBLE	❑	❑	_____	N) HEART MURMUR	❑	❑	_____
C) MEASLES	❑	❑	_____	I) KIDNEY DISEASE	❑	❑	_____	O) HEPATITIS	❑	❑	_____
D) SCARLET FEVER	❑	❑	_____	J) LUNG DISEASE	❑	❑	_____	P) AIDS	❑	❑	_____
E) CHICKEN POX	❑	❑	_____	K) ASTHMA	❑	❑	_____	Q) EPILEPSY	❑	❑	_____
F) MUMPS	❑	❑	_____	L) X-RAY THERAPY	❑	❑	_____	R) ABNORMAL BLOOD PRESSURE	❑	❑	_____

DENTAL HISTORY

1. Is this your child's first visit to a dentist? ..... YES NO
2. If not, has your child ever received a local anesthetic? ..... YES NO
3. Has your child ever received sealants? ..... YES NO
4. Have any cavities been noted in the past? ..... YES NO
5. Were any teeth (baby or permanent) removed by extraction? ..... YES NO
6. Have there been any injuries to your child's teeth, such as falls, blows, chips, etc.? ..... YES NO
   If so, (would you) explain? _____
7. Fluoride History:
   a) Do you live in a fluoridated area? ..... YES NO
   b) Do you give your child any form of fluoride tablets? ..... YES NO
   c) Has a dentist ever applied any fluoride to your child's teeth? ..... YES NO
8. Has your child ever had a bad medical or dental experience? ..... YES NO
   If so, explain? _____
9. Has anyone in the family, including parents, had orthodontics? _____ YES NO
   If so, who? _____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____

SIGNATURE OF DENTIST _____ DATE _____