



37 Hickory Drive
Random Lake, WI 53075
920.994.4367

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-Random Lake, 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

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

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

DENTAL HISTORY

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