FORT FAMILY DENTAL CENTER

715 E. Sherman Ave, Fort Atkinson, WI 53538 • 920-563-4322

PATIENT INFORMATION Please print

Date _____

We would like to get to know you better!

First Name:_____Last name: _____ Middle initial _____

Address: _____

City, State, Zip: _____

Home phone: (_____) _____-_____ Work phone: (_____) _____-_____ Cell: (_____) _____-_____

Email Address:_____

Where would you like us to contact you: ❑ Home ❑ Cell ❑ Work

Birth Date: _____ Age: _____ Soc Sec. _____

Sex ❑ Male ❑ Female Marital Status ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

Employment Status: ❑ Full Time ❑ Part Time ❑ Retired

Name of Employer_____ City, State: _____

Student Status: ❑ Full Time ❑ Part Time Name of School _____

Main Dental concern:_____

Do you use a pre-medication prior to dental treatment (antibiotic?) _____ Why? _____

How did you find our office (referral source) _____

EMERGENCY CONTACT:_____ Phone: (_____) _____-_____

PATIENT REGISTRATION

Responsible Party (if someone other than patient)

First Name:_____Last name: _____ Middle initial _____

Address: _____

City, State, Zip: _____

Home phone: (_____) _____-_____ Work phone: (_____) _____-_____ Cell: (_____) _____-_____

Birth Date: _____ Soc Sec. _____

❑ Responsible party is also the policy holder for patient ❑ Primary Insurance Holder ❑ Secondary Insurance Holder

DENTAL INSURANCE INFORMATION (please provide insurance card)

Name of Policy Holder: _____Policy Holder Birth Date: _____

Relationship of patient: ❑ Self ❑ Spouse ❑ Child ❑ Other Policy Holder SSN/ID _____

Address (if different than patient) _____

Name of Policy Holder's Employer:_____ City, State:_____

Name of Insurance Company:_____

Address: _____City, State, Zip_____

SECONDARY DENTAL INSURANCE INFORMATION (please provide insurance card)

Name of Policy Holder: _____Policy Holder Birth Date: _____

Relationship of patient: ❑ Self ❑ Spouse ❑ Child ❑ Other Policy Holder SSN/ID _____

Address (if different than patient) _____

Name of Policy Holder's Employer:_____ City, State:_____

Name of Insurance Company:_____

Address: _____City, State, Zip_____

HEALTH HISTORY

Physician's Name_____Phone #_____ Date of last visit _____

Place a mark on "yes" or "no" to indicate if you have or had any of the following:

	YES	NO
Acid Reflux	❑	❑
AIDS/HIV	❑	❑
Anemia	❑	❑
Arthritis, Rheumatism	❑	❑
Artificial Heart Valves	❑	❑
Artificial Joints	❑	❑
Asthma	❑	❑
Back Problems	❑	❑
Bleeding abnormally, with extractions or surgery	❑	❑
Blood Disease/Clotting disorder	❑	❑
Cancer	❑	❑
Chemical Dependency	❑	❑
Chemotherapy	❑	❑
Circulatory Problems	❑	❑
Congenital Heart Defect	❑	❑
Cortisone Treatments	❑	❑
Cough, persistent or bloody	❑	❑
Diabetes	❑	❑
Emphysema	❑	❑
Other _____	❑	❑

	YES	NO
Epilepsy	❑	❑
Fainting or dizziness	❑	❑
Glaucoma	❑	❑
Headaches	❑	❑
Heart Murmur	❑	❑
Heart Problems	❑	❑
Hepatitis Type _____	❑	❑
Herpes	❑	❑
High Blood Pressure	❑	❑
Jaundice	❑	❑
Jaw Pain	❑	❑
Kidney Disease	❑	❑
Liver Disease	❑	❑
Low Blood Pressure	❑	❑
Mitral Valve Prolapse	❑	❑
Nervous Problems	❑	❑
Pacemaker	❑	❑
Psychiatric Care	❑	❑

	YES	NO
Radiation Treatment	❑	❑
Respiratory Disease	❑	❑
Rheumatic Fever	❑	❑
Scarlet Fever	❑	❑
Shortness of Breath	❑	❑
Sinus Trouble	❑	❑
Skin Rash	❑	❑
Special Diet	❑	❑
Stroke	❑	❑
Swollen Neck Glands	❑	❑
Thyroid Problems	❑	❑
Tuberculosis	❑	❑
Tumor or growth on head or neck	❑	❑
Ulcer	❑	❑
Venereal Disease	❑	❑
Weight Loss, unexplained	❑	❑

Women:	YES	NO
Are you pregnant?	❑	❑
Are you nursing?	❑	❑
Taking birth control pills?	❑	❑

Due Date _____

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis

_____

_____

_____

_____

_____

_____

Pharmacy Name _____

Phone (_____)_____

ALLERGIES

- ❑ Aspirin
- ❑ Local Anesthetic
- ❑ Barbituates (Sleeping pills)
- ❑ Penicillin
- ❑ Codeine
- ❑ Sulfa
- ❑ Iodine
- ❑ Latex
- ❑ Other _____

_____

DENTAL HISTORY

Date of last exam/x-rays _____

Removal of wisdom teeth _____

_____

Orthodontic treatment _____

Frequency of Dental Flossing _____

Texture of toothbrush_____

Frequency of toothbrushing_____

Periodontal treatment _____

If you could change anything about your smile, what would it be? _____

_____

Updates _____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Patient Signature & Date

_____

Dr. Signature & Date

_____