Fisher Family Dental

308 N. Main St • DeForest, WI 53532 (608)842-0699

Chart#: _____ FOR OFFICE USE ONLY

Patient Name: _____ Last _____ First ___ MI

_____ Preferred Name

Title: **Gender:** _____ Mr/Ms/Mrs/etc ◯ Male ◯ Female

Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____

SS#: ___-__-____

Prev. Visit: _____

Email Address: _____

Best time to call: _____

Phone: _____ Home _____ Mobile _____ Work _____ Ext

_____ Fax _____ Other

Address: _____ Address 1

_____ Address 2

_____ City _____ State ____-____ Zip Code

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____

Phone: _____

Employer Address: _____ Address 1

_____ Address 2

_____ City

_____ State ____-____ Zip Code

Whom may we thank for referring you to our practice?

_____

In an emergency who should be notified? Please enter Name and Phone number below:

_____

_____

Primary Dental Insurance:

Name of Insured:

Last

First MI

Insured's Birth Date:

ID #: **Group #:**

Insured's Address:

Address 1

Address 2

City

State Zip Code

Insured's Employer Name:

Employer Address:

Address 1

Address 2

City

State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name:

Insurance Address:

Address 1

Address 2

City

State Zip Code

Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance to pay my benefits directly to the dentist for all services rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges, whether or not paid by insurance.

Medical History

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

- ☐ *Pre-Med - Amox
- ☐ Allergy - Aspirin
- ☐ Allergy - Latex
- ☐ Anemia
- ☐ Blood Disease
- ☐ Epilepsy
- ☐ Head Injuries
- ☐ High Blood Pressure
- ☐ Liver Disease
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Venereal Disease
- ☐ *Pre-Med - Clind
- ☐ Allergy - Codeine
- ☐ Allergy - Other
- ☐ Arthritis
- ☐ Cancer
- ☐ Excessive Bleeding
- ☐ Heart Disease
- ☐ HIV
- ☐ Mental Disorders
- ☐ Pregnancy
- ☐ Rheumatism
- ☐ Tuberculosis
- ☐ *Pre-Med - Other
- ☐ Allergy - Erythro
- ☐ Allergy - Penicillin
- ☐ Artificial Joints
- ☐ Diabetes
- ☐ Fainting
- ☐ Heart Murmur
- ☐ Jaundice
- ☐ Nervous Disorders
- ☐ Radiation Treatment
- ☐ Sinus Problems
- ☐ Tumors
- ☐ Allergies
- ☐ Allergy - Hay Fever
- ☐ Allergy - Sulfa
- ☐ Asthma
- ☐ Dizziness
- ☐ Glaucoma
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Other
- ☐ Respiratory Problems
- ☐ Stomach Problems
- ☐ Ulcers

- ☐ Ever been hospitalized (illness or injury)
- ☐ Taking medication for weight control (ie fen-phen)
- ☐ Subject to frequent headaches
- ☐ FEMALE: Taking birth control pills
- ☐ Presently being treated for any other illnesses
- ☐ Taking dietary supplements
- ☐ A smoker or smoked previously
- ☐ FEMALE: Pregnant

If any condition or alert selected above needs further clarification, please explain below:

_____

_____

Do you take antibiotic premedication for your dental visits? If yes, please explain.

_____

_____

What is your estimate of your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of physician, their specialty and date of last exam:

_____

_____

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment:

_____

_____

List all medications, supplements, and/or vitamins taken within the last two years:

_____

_____

☐ ***By checking this box, I acknowledge that the above information is correct and I understand it is my responsibility to inform the office of any changes in my health as soon as possible.**

Dental Information

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist name and how long you have been a patient there:

_____

_____

Date of most recent dental exam: _____

Date of most recent dental x-rays: _____

I routinely see my dentist every:

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

What is your immediate concern?

_____

_____

Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) _____

Personal History, Check all that apply:

☐ Had an unfavorable dental experience
☐ Had complications from past dental treatment
☐ Had trouble getting numb
☐ Had any reactions to local anesthetic
☐ Had/have braces, orthodontic treatment
☐ Had your bite adjusted
☐ Had any teeth removed

Smile Characteristics, Check all that apply:

☐ Is there anything about the appearance of your teeth that you would like to change?
☐ Have you ever whitened (bleached) your teeth?
☐ Have you felt uncomfortable or self conscious about the appearance of your teeth?
☐ Have you been disappointed with the appearance of previous dental work?

Bite and Jaw Joint, Check all that apply:

☐ You have problems with your jaw joint
☐ You have any problems chewing
☐ Your teeth changed in the last 5 years, become shorter, thinner, or worn
☐ Your teeth crowding or developing spaces
☐ You chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits
☐ You clench you teeth in the daytime or make them sore
☐ You have problems with sleep or wake up with an awareness of your teeth
☐ You wear or have worn a bite appliance

Tooth structure, Check all that apply:

☐ Cavities within past 3 years
☐ The amount of saliva in your mouth seems too little or you have difficulty swallowing any food
☐ You notice or have holes (i.e. pitting, craters) on the biting surface of your teeth
☐ Any teeth sensitive to hot, cold, biting, sweets, or you avoid brushing any part of your mouth
☐ Any teeth with grooves, notches, chips, a cracked filling or pain
☐ Food gets caught between any teeth

Gum and Bone, Check all that apply:

- ☐ Gums bleed when brushing or flossing
- ☐ Treated for gum disease or were told you have lost bone around your teeth
- ☐ Noticed an unpleasant taste or odor in your mouth
- ☐ History of periodontal disease in your family
- ☐ Experienced gum recession
- ☐ Had any teeth become loose on their own (without injury), or have difficulty eating an apple
- ☐ Experienced a burning sensation in your mouth

If any of the checked boxes need further explanation, please describe:

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Dental Practice Financial Policy

The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient will be determined before treatment.

We will collect all payments (co-payments) at time of service.
We file Insurance as a courtesy to our patients.
The patient portion we collect at the time of service is only an estimate and there may be additional monies owed after insurance pays.

There are no discounts that can be given with Insurance or Membership Plans.

Signature of guarantor of payment/responsible party:

Signature:_____

Notice of Privacy Practices Acknowledgment.

The privacy of your health information is important to us. Our Notice of Privacy Practices describes how your health information will be handled in various situations.

We ask that you sign this form to acknowledge that you received a copy of our Notice of Privacy Practices.

We will release your information to your dental insurance for authorization and payment, specialists that you may referred to for care, or any other person you so wish and list below:

_____

_____

Signature of patient, parent, or guardian (responsible party):

Signature_____

☐ **By checking this box, I acknowledge that I have read, and fully understand and agree to the terms of this Financial Policy and HIPAA**