FISHER FAMILY DENTAL
308 N. Main Street, DeForest, WI 53532 608-842-0699

New Patient Information

Patient Name:

Last: _____ First: _____ M.I.: ____ Preferred: _____

Family Status: ☐Married ☐Single ☐Other

Gender: _____ Birthdate: _____ SSN: _____

Email Address: _____

Phone: _____(H) _____(W) _____(C)

Address: _____

_____

Employer: _____ Phone: _____

Insurance Information:

Name of Policy Holder: _____ D.O.B: _____

Policy Holder ID Number: _____ Group #: _____

Name of Insurance: _____ Insurance Phone #: _____

I authorize my insurance to pay my benefits directly to the dentist for all services rendered. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand I am financially responsible for all changes, whether or not paid by insurance.

Signature: _____ Date: _____

Emergency Contact Information:

Name: _____ Phone: _____

Whom may we thank for referring you to our office: _____

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Medical History

Name: _____ **Date:** _____

Indicate which of the following you have had or have at present. Checking the box indicates a "Yes" response, leaving blank indicates a "No" response.

☐ Anxiety	☐ Dizziness/Fainting	☐ HIV	☐ Seizures
☐ Anemia/Blood Disorder	☐ Epilepsy	☐ HPV	☐ Sinus Problems
☐ Arthritis	☐ Excessive Bleeding	☐ Kidney Disease	☐ Smoking/Tobacco Use
☐ Artificial Joints	☐ G.I. Problems	☐ Liver Disease	☐ Stroke
☐ Asthma	☐ Glaucoma	☐ Mental Health Condition	☐ Thyroid Problems
☐ Auto-Immune Diseases	☐ Head Injuries	☐ Migraine/Headaches	☐ Tuberculosis
☐ Cancer	☐ Heart Disease	☐ Pacemaker	☐ Tumors
☐Chemotherapy/Radiation	☐ Hepatitis	☐ PTSD	☐ Ulcers
☐ Diabetes	☐ High Blood Pressure	☐ Respiratory Problems	☐ Other _____

Are you allergic to:

☐Amoxicillin	☐ Aspirin	☐ Codeine	☐Other (please list below)
☐Penicillin	☐Sulfa	☐Seasonal/Environmental	

☐ History of Bisphosphonates/Fosamax (oral or I.V.)	☐ History of Bacterial Endocarditis
☐ History of Heart Value Replacement	☐ Presently being treated for any other illnesses
☐ FEMALE: Currently Pregnant or Nursing (circle one)	☐ FEMALE: Taking birth control pills

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

_____

_____

List past medical surgeries and dates:

_____

_____

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

_____

_____

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

_____

_____

List all medications, supplements, and/or vitamins you are currently taking:

_____

_____

_____

_____

☐**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

Print name: _____ Date: _____

How would you rate the condition of your mouth?

Excellent Good Fair Poor

Previous dentist name: _____ How long were you a patient there? _____

Date of most recent dental exam: _____ Date of most recent dental X-rays: _____

I routinely see my dentist every:

3 mos. 4 mos. 6 mos. 12 mos. 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 any reactions to local anesthetic
- ☐Cavities within the last 3 years
- ☐Oral habits/bite your nails/use teeth to hold objects
- ☐Had complications from past dental treatment
- ☐Had trouble getting numb
- ☐Had/have braces (orthodontics)
- ☐Currently wear orthodontic retainer(s)

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 – pain, clicking or popping of joint
- ☐Your teeth have changed in the last 5 years, become shorter, thinner, or worn
- ☐Your teeth are crowding or developing spaces
- ☐You had your bite adjusted
- ☐You clench and/or grind your teeth or notice jaw soreness during the daytime or wake up with a sore jaw
- ☐You wear or have worn a bite appliance/night guard

Tooth Structure – Check all that apply:

- ☐History of dry mouth or the amount of saliva in your mouth seems too little or you have difficulty swallowing food
- ☐You notice "holes," grooves, notches, chips, or cracks in any teeth
- ☐Any teeth sensitive to hot, cold, sweets, biting, or you avoid brushing any part of your mouth
- ☐Food gets caught between any teeth

Gum and Bone – Check all that apply:

- ☐Gums bleed when brushing or flossing
- ☐Treated for gum disease/have lost bone around 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 without injury
- ☐Experienced a burning sensation in your mouth
- ☐History of deep cleaning/scaling and root planning

Sleep and Breathing – Check all that apply:

- ☐Do you wake up feeling tired despite a full night's sleep?
- ☐Do you wake with morning headaches or sweaty?
- ☐ Do you mouth breath?
- ☐ Have you ever been told you snore?
- ☐Have you ever been diagnosed with a sleep related breathing disorder (i.e., obstructive sleep apnea)
- ☐PEDIATRIC: Any history of bed wetting?

If any checked boxes need further explanation, please describe:

_____

_____

_____

_____

Is there anything we should know to give you more comfortable care, please describe:

_____

_____

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Dental Practice Financial Policy

Print name: _____

The practice depends upon reimbursement from patients for the costs incurred in their care. We file insurance as a courtesy to our patients.

1. We will collect all payments (co-payments) at time of service. The patient portion we collect at the time of service is only an estimate and there may be additional payment owed after insurance pays.
2. If an appointment is missed or cancelled with less than 24 hour notice, a fee will be assigned to the patient's account. This fee will be $50 per appointment.
3. If a balance on an account goes past 90 days, a finance charge of 1.5% per month or 18% per year will be added.
4. There are no discounts that can be given with Insurance or Membership Plans.

Signature of patient or responsible party: _____

Date: _____

Notice of Privacy Practices Acknowledgment.

The privacy of your health information is a top priority. 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 be referred to for care, or any other person you so wish and list below:

_____

I consent to receive electronic information from Fisher Family Dental.

Signature of patient or responsible party: _____

Date: _____