DENTAL HISTORY

PATIENT NAME: ____ DATE: ____________

Have you ever experienced any of the following:

- ☐ Toothaches
- ☐ Bad Breath
- ☐ Pain in chewing
- ☐ Canker Sores
- ☐ Other sore areas in your mouth
- ☐ Bleeding Gums
- ☐ Clenching or Grinding your teeth
- ☐ Pain or popping in or near your ear
- ☐ Frequent Headaches
- ☐ Gum Surgery
- ☐ Bridges or Partial Dentures
- ☐ Dental Implants
- ☐ Orthodontic Treatment

Has anyone ever instructed you how to:
Brush: YES NO
Floss: YES NO

How often do you brush your teeth? ____

How often do you floss your teeth? ____

When was your last dental visit? 6mo 1 yr 2 yr 2yr+

Did you have Dental x-rays taken: YES NO

Do you have regular dental check-ups: YES NO

Do you like your smile? ____

What would you like to change about your smile? ________________________________

What did you like about your past dentist? ____

Why are you changing dentists? ____

Is there anything you don't like about dental appointments?

____

What could we do to make your dental visits more comfortable?

____

Acknowledgement of Receipt of Notice of Privacy Practices

I, ____, have received/read a copy of this office's Notice of
Please Print Patient Name
Privacy Practices.

Falls Dental Associates may contact you, by e-mail, telephone, text or mail to provide appointment reminders. You must notify us if you do not want to receive reminders or be contacted through one of the forms of communication listed above. We will use professional judgement to make reasonable decisions in your best interest when determining if another person acting on your behalf may pick up filled prescriptions, medical supplies, x-rays, or other similar forms of protected health information.

____ _______________
Signature of Patient or Personal Representative Date
(If personal representative please describe relationship)

____

Persons involved in Care:

You may choose if you would like specific individuals other then yourself to have access to information about your Dental Care. Please list below the person(s) you would like to have access to your dental care and/or payment of that care.

Name: _______________________________ Name: _______________________________

Address: _____________________________ Address: _____________________________

_____________________________________ _____________________________________

Phone #: _____________________________ Phone #: _____________________________

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please specify) ____

____________________________________ _______________
Employee Signature Date

Fax Number: 262-253-4895 E-mail Address: info@fallsdental.com

As your Dental Provider, we have an obligation to you, to:

- Provide an accurate diagnosis of your dental problems.
- Provide you with a treatment plan to address these problems and suggest treatment alternatives when available.
- Inform you of the fees involved for the treatment proposed.

For our Patients with Dental Insurance:

- Upon the start of every appointment, we will ask to verify your insurance information for our records.
- It is your responsibility to provide current and accurate insurance information, including updates and changes in your insurance coverage.
- All insurance coverage discussions are estimates, not a guarantee of payment by your insurance company.
- We will file insurance claims on your behalf, with the insurance you have provided us at the time treatment is provided. Insurance that has not paid on services after 90 days will become your complete responsibility and must be paid in full by the designated responsible party on the account.
- If my Insurance company denies coverage or payment for services provided, I assume full financial responsibility and will pay all such charges in full.
- Referrals, if necessary, will be based on the insurance information that you have provided.

Please fill out the following information if you would like Falls Dental Associates to submit services to your Dental Insurance:

Primary Insurance

Patient Name: ______________________________

Name of Insurance: ______________________________

Group Number for Insurance: ____________________ Subscriber ID: ____________________

Name of person who carries your Dental Insurance (Subscriber):____________________

Subscriber's Date of Birth:____________ Subscriber's Social Security Number: ____________________

Subscriber's Address:______________________________ City: ____________

State:____________ Zip: __________

Subscriber's Home/Cell Phone:____________________

Patient/Guardian without Insurance and Patient/Guardian with Insurance please sign:

I have read all terms stated above. My signature serves as acknowledgement of a clear understating of my responsibility.

______________________________ ____________

Patient/Guardian Date

Falls Dental Associates

N85W16093 Appleton Avenue • Menomonee Falls, WI 53051-3099 (262)253-9797

Chart#: ____________
FOR OFFICE USE ONLY

Patient Name: ____________ ____________ ____ ____________
Last First MI Preferred Name

Title: ________ **Gender:** ○ Male ○ Female **Family Status:** ○ Married ○ Single ○ Child ○ Other
Mr/Ms/Mrs/etc

Birth Date: ____________

Prev. Visit: ____________

Email Address: ________________________

Phone: ________ ________ ________ ____ **Best time to call:** ____________
Home Mobile Work Ext

Address: ________________________ ________________________
Address 1 Address 2

________________________ ________ _____-____
City State Zip Code

Patient's Social Security Number: * ____________

Conditions:

☐ Acid Reflux/GERD	☐ AIDS/HIV	☐ Allergy to Latex	☐ Allergy to Metal
☐ Allrg. to Anesthetic	☐ Allrg. to Penicillin	☐ Alzheimers	☐ Anemia
☐ Arthritis	☐ Artif. Heart Valve	☐ Artificial Joint	☐ Bisphosphonates
☐ Bleeding Disorder	☐ Breathing Difficulty	☐ Chemotherapy	☐ Dementia
☐ Diabetes I or II	☐ Dizziness/Fainting	☐ Epilepsy	☐ Head Injuries
☐ Hearing Impaired	☐ Heart Disease/Attack	☐ Hepatitis	☐ High Blood Pressure
☐ Jaundice	☐ Kidney Disease	☐ Liver Disease	☐ Mental Illness
☐ Nervous Disorders	☐ Organ Transplant	☐ Other	☐ Pacemaker
☐ Past Addictions	☐ Pregnancy	☐ Radiation Treatment	☐ Respiratory Disease
☐ Rheumatic Fever	☐ Sensitivity to Epi	☐ Sinus Problems	☐ Stroke
☐ Tuberculosis	☐ Tumor/Growth/Cancer		

Please explain any conditions marked above:

____

____

Please list any other allergies:

____

____

Are there any other medical conditions about which we should know? Your medical health may affect our dental treatment. Please explain below:

____

____

Do you take any medications regularly? ○ Yes ○ No

if YES, please list current medications:

____

____

Are you currently under medical care? ◯ Yes ◯ No

If YES, please explain:

____

____

Date of your last physical exam: ________________________

Physician's Name: ________________________

Physician's phone number: ________________________

Date of your last Dental Visit: ________________________

Party to notify in case of emergency: ________________________

Emergency contacts phone number and address: ________________________

Are you in good health? ◯ Yes ◯ No

Do you use tobacco products? ◯ Yes ◯ No

Patient (Responsible Party) Signature: * ________________________

Date: ________________________

Response Date: ___________