Patient Information and Health History

Patient Name	Sex □ Female □ Male	Social Security Number
Preferred Name	Birthdate	Email Address
Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed	Home Phone	Cell Phone
Home Address	City	State, Zip
Employer	Occupation	Work Phone
Business Address	City	State, Zip
Spouse's Name (if applicable)	Spouse's Birthdate	Spouse's Phone Number
Spouse's Employer	Spouse's Occupation	Spouse's Work Phone
Spouse's Business Address	City	State, Zip

Responsible Party (If other than patient)

Name	Birthdate	Social Security Number
Home Address	City	State, Zip
Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed	Relationship to patient	Phone Number

In the event of an emergency, please contact:

Name _____ Relationship_____ Phone Number _____

Name _____ Relationship _____ Phone Number _____

How did you hear about our office?

Who selected this office? □ Self □ Spouse □ Parent □ Employer

Where did you find the phone number to this office? □ Referred by a friend/relative □ Phone book □ Insurance plan □ TV/Radio/News Ad □ Other

If you were referred, whom may we thank for referring you? _____

How would you like to be reminded of your appointments?

□ Home Phone # □ Cell Phone # □ Work Phone # □ Text Message □ Email: _____

Consent

I will answer all health questions on this form to the best of my knowledge _____
(initial here)

Terms and Conditions

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits or another dentist.
I authorize and consent to the taking of photographs before, during, and after treatment. I further give permission for the use of those photographs for the purpose of research and education.
I understand that I am responsible for all costs of dental treatment.
I understand that I have a right to my dental records and that there may be a fee associated with receiving such records.
I hereby authorize payment of insurance benefits directly to the dentist or dental group.
I attest that the above information is complete and accurate.
MAC Dental does not accept any patients with insurance though the State of Wisconsin (such as Badger Care, Medical Assistance, Title 19, Forward Health, etc). By signing this form, I am stating that I am not covered under any state dental plan.

Signed _____ Date _____

There may be a charge for any missed appointments or appointments not cancelled 24 hours prior to appointment time.

Why have you come in to see us today? (e.g. pain, check-up, etc) _____

Previous Dentist _____ Last Visit _____ Date of last cleaning _____

Reason for changing dentists _____

Have you had any problems with past dental treatment? _____

Are you nervous about seeing a dentist? □ Yes □ No If yes, please tell us why _____

How often do you brush? _____ Do you floss? □ Yes □ No If yes, how often? _____

Y	N	I clench or grind my teeth during the day or while sleeping	Y	N	My gums feel tender or swollen
Y	N	My gums bleed while brushing or flossing	Y	N	I have problems eating
Y	N	I like my smile	Y	N	I have had orthodontics
Y	N	I avoid brushing part of my mouth due to pain	Y	N	I have had a facial or jaw injury
Y	N	I want my teeth whiter	Y	N	I want my teeth straight
Y	N	I feel my bite is even	Y	N	I have a dental implant

What are your dental priorities? (e.g. dental health, financial considerations, etc) _____

I consider my health to be □ Excellent □ Good □ Fair □ Poor Date of last physical exam _____

Are you under a physician's care right now? □ Yes □ No If yes, please explain _____

_____

Have you ever been hospitalized or had a major operation? □ Yes □ No If yes, please explain _____

_____

Do you need to pre-medicate with an antibiotic prior to any dental treatment? □ Yes □ No

Have you ever had a serious head or neck injury? □ Yes □ No If yes, please explain _____

_____

Have you traveled outside of the U.S.A. within the last month? □ Yes □ No If yes, where? _____

Have you ever taken bone-loss drugs during cancer treatment? □ Yes □ No

Do you use tobacco? □ Yes □ No If yes, what type? _____ How often? _____

Do you use controlled substances? □ Yes □ No If yes, what type? _____ How often? _____

Women Only: Are you □ Pregnant □ Trying to get pregnant □ Nursing □ Taking oral contraceptives

Are you allergic to any of the following: □ Aspirin □ Ibuprofen □ Sulfa Drugs/Sulfites/Sulfides □ Penicillin family □ Codeine □ Latex

□ Plastic □ Metals, please list _____ □ Nuts, please list _____ □ Local Anesthetics (Novocaine)

Any other allergies, please list _____ Do you carry an epi pen? □ Yes □ No

Do you have or have you had any of the following (please check)

○ AIDS/HIV Positive	○ Chest Pains	○ Frequent Headaches	○ Hypoglycemia	○ Sickle Cell Disease
○ Alzheimer's Disease	○ Cold Sores	○ Glaucoma	○ Irregular Heartbeat	○ Sinus Trouble
○ Anaphylaxis	○ Congenital Heart Disorder	○ Gout	○ Kidney Problems	○ Sleep Apnea
○ Anemia	○ Convulsions	○ Hay Fever	○ Leukemia	○ Snoring
○ Angina	○ Cortisone Medicine	○ Heart Attack/Failure	○ Liver Disease	○ Spina Bifida
○ Anxiety	○ CPAP	○ Heart Murmur	○ Low Blood Pressure	○ Stomach/Intestinal Disease
○ Arthritis	○ Dental Implants	○ Heart Pace Maker	○ Lung Disease	○ Stroke
○ Artificial Heart Valve	○ Depression	○ Heart Trouble /Disease	○ MRSA	○ Swelling of Limbs
○ Artificial Joint	○ Diabetes	○ Heartburn/GERD	○ Organ Transplant	○ Thyroid Disease
○ Asthma	○ Drug Addiction	○ Hemophilia	○ Osteoporosis	○ Tonsillitis
○ Auto Immune Disease	○ Easily Winded	○ Hepatitis A	○ Pain in Jaw Joints	○ Tuberculosis
○ Blood Disease	○ Emphysema	○ Hepatitis B or C	○ Parathyroid Disease	○ Tumors or Growths
○ Blood Transfusion	○ Epilepsy or Seizures	○ Herpes	○ Radiation Treatment	○ Ulcers
○ Breathing Problem	○ Excessive Bleeding	○ High Blood Pressure	○ Recent Weight Loss	○ Venereal Disease
○ Bruise Easily	○ Excessive Thirst	○ High Cholesterol	○ Renal Dialysis	○ Yellow Jaundice
○ Cancer	○ Fainting Spells /Dizziness	○ History of Osteoporosis	○ Rheumatic Fever	
○ Celiac Disease	○ Frequent Cough	○ Hives or Rash	○ Rheumatism	
○ Chemotherapy	○ Frequent Diarrhea	○ HPV 16	○ Shingles	

Have you ever had any serious illness not listed above? □ Yes □ No If yes, please explain _____

Please list all medications you are currently taking:

Medicine _____ Condition _____

Medicine _____ Condition _____

Medicine _____ Condition _____

Medicine _____ Condition _____

I attest that the above information is complete and accurate.

Signed _____ Date _____