Fond du Lac Family Dentistry

We Would Like To Get To Know You Better

First Name _____ Last _____ M.I. ____ Male □ Female □ Date of Birth _____
Address _____ City _____State _____ Zip _____
Home Phone _____Cell _____ Work _____
Employer _____ Occupation _____ D.L. _____
Employer Address _____
Spouse's Name _____ Employer _____ Occupation _____
Employer Phone _____ Who referred you to our office? _____
Person responsible for dental investment _____ **Email:** _____

Insurance

Name of Primary Insurance Company _____
Whose _____SS Number _____ Member Number _____
Name of Secondary Insurance Company _____
Whose _____SS Number _____ Member Number _____

Medical History

	Yes	No
Are you currently under a physicians care?	□	□
Reason: _____Date of your last check-up:_____		
Any significant findings?_____		
Are you on any medications? (Prescription, OTC and Supplements)	□	□
Please list: _____		
_____		
Have you had surgery or hospitalizations in the last five years?	□	□
Please list: _____		

To the best of your knowledge do you or have you ever had:

	Yes	No
Need pre-medication for dental appointments	□	□
Heart condition_____	□	□
Diabetes	□	□
Rheumatic Fever	□	□
Epilepsy	□	□
High / Low blood pressure	□	□
Respiratory Disease	□	□
Hepatitis	□	□
Aids / HIV	□	□
Blood disorder or prolonged bleeding	□	□
Stroke	□	□

	Yes	No
Healing complications	□	□
Sinus conditions	□	□
Arthritis _____	□	□
Cancer _____	□	□
Asthma	□	□
Allergy to any drug, anesthetic or latex	□	□
_____		
Are you pregnant?	□	□
Do you use tobacco products? _____	□	□
_____		
Have you had bisphonsphonate therapy?	□	□

Other _____

I hereby authorize release of any information, including the diagnosis and records or treatment or examinations rendered, to my insurance company or companies. I authorize payment directly to the doctor, of insurance benefits to which I am entitled.

Signature _____ Date _____