



## Thank You For Selecting Our Dental Team.

We are pleased to welcome you to our practice. Please take a few minutes to complete the following information so we can better care for you. It is our goal to help you reach and maintain maximum oral health.

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Name: \_\_\_\_\_

I prefer to be called \_\_\_\_\_

Male Female Married Single Other

Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ S.S.#: \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Hm # \_\_\_\_\_ Cell # \_\_\_\_\_

Wk # \_\_\_\_\_ Pgr # \_\_\_\_\_

E-mail Address \_\_\_\_\_

Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

Occupation: \_\_\_\_\_

How would you prefer to be contacted?

Cell Hm Phone Wk Phone

Email Text Pgr

Whom may we thank for referring you?

\_\_\_\_\_

Other Family Members seen by us?

\_\_\_\_\_

Previous / Present Dentist: \_\_\_\_\_

Last Visit Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Ph# \_\_\_\_\_

**In the events of an emergency, is there someone who lives near you that we should contact?**

Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Wk#: \_\_\_\_\_

Hm#: \_\_\_\_\_

### Primary Dental Insurance

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_

Group # (plan, Local or Policy#): \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relation \_\_\_\_\_

Insured's Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_

Insured's S.S.# \_\_\_\_\_

**Secondary Insurance Name:** \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relation \_\_\_\_\_ S.S.#: \_\_\_\_\_ BD \_\_\_\_/\_\_\_\_/\_\_\_\_

### *A note for our patients with dental insurance-*

We will assist you in anyway possible to maximize your insurance benefits. We are happy to file claims to your insurance carrier and agree to accept payment from any carrier that offers an assignment of benefits, if you desire. We will do our best to make as close of a calculation as possible of what your insurance plan will cover, however regardless of what your insurance plan pays, you are responsible for all fees.

### *Appointment Cancellation Policy-*

Please help us to deliver the best quality dental care by keeping scheduled visits. If you are unable to keep your appointment give at least 48 hours notice. We reserve the right to charge \$50.00 per hour for appointments canceled with less than adequate notice.



# Medical History

Are you currently under the care of a physician? If yes please describe.

Are you currently taking prescription or OTC drugs of any kind? If yes please list.

Women Only: Are you pregnant? \_\_\_\_\_ Are you nursing? \_\_\_\_\_  
Are you taking oral contraceptives? \_\_\_\_\_

**Do You have, have had, or been treated for, any of the following?:**

- |                             |  |
|-----------------------------|--|
| Y N ARTHRITIS               | Y N HEMOPHILIA, BLEEDING OR BLOOD DISORDER |
| Y N RHEUMATIC FEVER         | Y N THYROID CONDITION                      |
| Y N HEART PROBLEMS          | Y N VENEREAL DISEASE                       |
| Y N HIGH BLOOD PRESSURE     | Y N PACEMAKER                              |
| Y N LOW BLOOD PRESSURE      | Y N HIP OR JOINT REPLACEMENT               |
| Y N ANEMIA, SICKLE CELLULAR | Y N FAINTING SPELLS                        |
| Y N EPILEPSY, SEIZURES      | Y N DIABETES                               |
| Y N CHEMICAL DEPENDENCY     | Y N RADIATION THERAPY                      |
| Y N HEPATITIS A or B or C   | Y N EAR INFECTION                          |
| Y N ULCERS                  | Y N CHONIC SINUS INFECTION                 |
| Y N KIDNEY DISORDER         | Y N ASTHMA                                 |
| Y N TUBERCULOSIS            | Y N AIDS RELATED COMPLEX                   |
| Y N ANOREXIA, BULIMA        | Y N HEART MURMUR                           |
| Y N PHEN-PHEN OR REDUX      | Y N MITRAL VALVE PROLAPSE                  |

**Do you Have any reactions to or are you allergic to:**

- |                                   |                                     |
|-----------------------------------|-------------------------------------|
| Y N LOCAL ANESTHETICS             | Y N ERYTHROMYCIN                    |
| Y N ASPIRIN OR IBUPROFEN (Advil)  | Y N ACETAMINOPHEN (Tylenol)         |
| Y N BARBITURATES OR TRANQUILIZERS | Y N SULFA DRUGS                     |
| Y N CODEINE or other NARCOTICS    | Y N ANY OTHER MEDICATIONS OR DRUGS? |
| Y N LATEX MATERIALS               |                                     |
| Y N PENICILLIN                    |                                     |

Why have you come to the dentist today? \_\_\_\_\_

How would you describe the condition of your teeth or gums on a scale of 1 to 10? 10 being the best \_\_\_\_\_

Are you currently in pain or discomfort with your teeth and gums? Y or N

If yes, explain: \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_ How often do you floss your teeth? \_\_\_\_\_

Do your gums bleed when you floss or brush your teeth? Y or N

Have you ever experienced pain in your jaw joint? Y or N

Do you use tobacco products? Y or N

I understand that the information is correct to the best of my knowledge and it will be held in the strictest confidence. It is my responsibility to inform this office of any changes in my medical status. I authorize the release of information for insurance purposes and give consent for Dr. Mullenau and his staff to treat me. I authorize Dr. Mullenau and/or his staff to take photos of my care and treatment, which may be used for the advancement and educational viewing by other dentists, staff or patients. Dr Mullenau and his staff cannot reveal my identification without my permission. I am responsible for payment.

Signature: \_\_\_\_\_ (If under 18 Parent or Guardian) Date: \_\_\_\_\_