

NEW PATIENT QUESTIONNAIRE

Today's Date: _____ Birth Date: _____ Sex: _____

Full Name: _____ Soc. Sec. #: _____

Home phone: () _____ Cell phone: () _____

Address: (Street) _____

City, State, Zip: _____

May we contact you via E-mail? _____ E-mail address: _____

Place of Employment: _____ Work phone: () _____

Name of Employer: _____ Can we call you at work? _____

Employer's Address: _____

City, State, Zip: _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____

If a minor, Father's Name & Work Ph. _____

Mother's Name & Work Ph. _____

If married, Spouse's Name _____ Work Ph. _____

Spouse's Place of Employment: _____

** All information needs to be complete to process insurance claims.*

Policy Holder's Name: _____

Policy Holder's Birth Date: _____ Policy Holder's SS# _____

Relationship of Patient to Policy Holder: _____ Group # _____

Name of Dental Insurance/Address: _____

Policy Holder's Place of Employment (Street, City State): _____

** If there is secondary insurance fill out the following.*

Policy Holder's Name: _____

Policy Holder's Birth Date: _____ Policy Holder's SS# _____

Relationship of Patient to Policy Holder: _____ Group # _____

Name of Dental Insurance/Address: _____

Policy Holder's Place of Employment (Street, City State): _____

Please list who or how you heard about our office? _____

** May we send a Thank You to him/her? Yes No*

Date of your last visit to a Dentist? _____

Reason for last dental visit? _____

Would you prefer your dental records transferred here? Yes No

If so, name and address of previous dentist? _____

** During a dental visit or relating to your dental health, have you ever:*

1. Fainted? _____

2. Had an allergic reaction? _____

3. Had abnormal bleeding? _____

4. Do your gums bleed when brushing or flossing? _____

5. Had any other complications during or following dental treatment? _____

6. Have your teeth shifted, are there spaces between your teeth now where there were none, are your teeth flaring, or are some of your teeth becoming loose? _____

7. Are any of your teeth sensitive to heat or cold? _____

8. Do you grind your teeth or clench your jaws? _____

9. Do you have pain or clicking in the jaw joint around your ear? _____

10. Are there any sores or growths in your mouth? _____

11. Do any of your teeth ache? _____

12. Do you have any removable partials/dentures or dental implants? _____

13. Do you have any other dental complaint? _____

Date: _____

Person completing this form: (Please PRINT) _____

Your signature: _____

If other than patient, indicate relationship: _____

COMPLETE CONFIDENTIAL MEDICAL HISTORY

Patient Name: _____ **Date of Birth:** _____

The following information is essential for this office to provide dental care in a manner that is compatible with your general health. Your cooperation in providing accurate information is necessary to meet your dental needs safely and efficiently. Incorrect information can be dangerous to your health.

Name & Address of Medical Doctor, date of last visit and reason: _____

<p>Are you currently taking ANY medications? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If so, please list each medication & for what condition:</p> <p>I have submitted a list of all my current medications & for what condition for my dental record: <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
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Place a **X** on the appropriate YES or NO box for EACH QUESTION below and explain ALL YES answers at the bottom of the form. If the question is not understood, you are not certain of the answer, or have any questions, indicate so by placing a question mark ? near the question asked and discuss the matter with your doctor.

TO ALL PATIENTS - HAVE YOU EVER HAD OR BEEN TREATED FOR THE FOLLOWING:

	YES	NO		YES	NO
1. Are you currently taking any "herbal" medications?	<input type="checkbox"/>	<input type="checkbox"/>	9. Abnormal (high or low) blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you consent to necessary diagnostic photos & x-rays?	<input type="checkbox"/>	<input type="checkbox"/>	10. Stroke, diabetes or excessive bleeding?	<input type="checkbox"/>	<input type="checkbox"/>
3. Had Rheumatic fever, rheumatic heart disease, heart murmur, congenital heart disease or mitral valve prolapse?	<input type="checkbox"/>	<input type="checkbox"/>	11. Heart trouble, heart attack, angina, heart surgery, pacemaker or defibrillator placed?	<input type="checkbox"/>	<input type="checkbox"/>
4. Heart valve replacement?	<input type="checkbox"/>	<input type="checkbox"/>	12. Stomach problems, ulcers or intestinal disease?	<input type="checkbox"/>	<input type="checkbox"/>
5. Any artificial joints placed? (Hip, knee, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	13. Breathing problems, asthma or hay fever?	<input type="checkbox"/>	<input type="checkbox"/>
6. Allergic reactions to latex, metals or plastic?	<input type="checkbox"/>	<input type="checkbox"/>	14. Tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>
7. Seasonal/environmental allergies, hives or skin rash?	<input type="checkbox"/>	<input type="checkbox"/>	15. Hepatitis, jaundice or liver disease?	<input type="checkbox"/>	<input type="checkbox"/>
8. Allergic reactions to any types of food?	<input type="checkbox"/>	<input type="checkbox"/>	16. Persistent/productive cough or do you cough up blood?	<input type="checkbox"/>	<input type="checkbox"/>

Please explain & date your "YES" answers here:

	YES	NO		YES	NO
17. Allergic reactions to medications?	<input type="checkbox"/>	<input type="checkbox"/>	26. Night sweats or weight loss?	<input type="checkbox"/>	<input type="checkbox"/>
18. Cancer, non-diagnostic x-ray treatments or chemotherapy?	<input type="checkbox"/>	<input type="checkbox"/>	27. Kidney problems or renal dialysis?	<input type="checkbox"/>	<input type="checkbox"/>
19. Tumors or growths?	<input type="checkbox"/>	<input type="checkbox"/>	28. Convulsions, fainting spells or seizures?	<input type="checkbox"/>	<input type="checkbox"/>
20. Venereal disease or AIDS?	<input type="checkbox"/>	<input type="checkbox"/>	29. Arthritis or rheumatism, painful or swollen joints?	<input type="checkbox"/>	<input type="checkbox"/>
21. Have you ever been exposed to the HIV virus?	<input type="checkbox"/>	<input type="checkbox"/>	30. Have you ever had a major operation?	<input type="checkbox"/>	<input type="checkbox"/>
22. Have you ever tested positive for the HIV virus?	<input type="checkbox"/>	<input type="checkbox"/>	31. Have you ever had a serious injury to your head or neck?	<input type="checkbox"/>	<input type="checkbox"/>
23. Do you use any TOBACCO products? Cigarettes or chew	<input type="checkbox"/>	<input type="checkbox"/>	32. Do you take drugs for recreational use?	<input type="checkbox"/>	<input type="checkbox"/>
24. Do you have a surgical implant to improve your hearing?	<input type="checkbox"/>	<input type="checkbox"/>	33. Are there any other problems with your health of which you are aware of?	<input type="checkbox"/>	<input type="checkbox"/>
25. Are you currently, or have you in the past, taken Fosamax, Actenol, or Boniva? <small>(Please circle which have been taken)</small>	<input type="checkbox"/>	<input type="checkbox"/>	→ If yes, how long have you taken the medication?		
WOMEN:					
34. Are you currently taking birth control pills?	<input type="checkbox"/>	<input type="checkbox"/>	→ If yes, what type?		
35. Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	→ If yes, approximately how far along are you?		
<i>Please explain & date your "YES" answers here:</i>					
ADDITIONAL DENTAL QUESTIONS:					
Would you like to discuss teeth whitening?	<input type="checkbox"/>	<input type="checkbox"/>	Would you like to discuss teeth straightening?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have family members or friends who could benefit from our services?				<input type="checkbox"/>	<input type="checkbox"/>

**** To the best of my knowledge, the above questions have been accurately answered. Note: A change in your health status should be reported to the office at the earliest possible time. The patient, parent or guardian has read and understands the policies of this office and hereby consents to treatment on that basis.**

Today's Date: _____

Person completing this form: (Print) _____

Your Signature: _____

If other than patient, indicate relationship: _____

DENTAL ASSOCIATES

Of Prairie du Chien, P.C.



To All Our Patients:

Our staff and Doctors wish to thank you for your confidence in allowing us to address your family's dental needs. We make every effort to offer our patients state of the art techniques and apply all new, practical, and positive developments to our dental practice. To keep our professional office on a sound business basis, we seek your help in complying with an office policy that will enable us to offer you the best possible service at the lowest fee. The costs for dental services, like the costs of many other services we receive, are based on a great many factors such as rent, wages, insurance, supplies, lab fees, lights, heat and numerous other expenses. We need your cooperation to help us hold our expenses and in turn, our fees, to a minimum. For these reasons the following financial policy is in effect in our office:

- * Many dental procedures are accomplished at one visit. Examples include fillings, extractions, and polishing teeth. If you do not have dental insurance, full payment is required the day the service is rendered. We accept *MasterCard, Visa, Discover or American Express*. For prepaid extensive treatment plans, we offer a bookkeeping courtesy savings with our VIP plan. Ask our receptionist for the specific details of our VIP plan.
 - If these options do not fit your budget, simply consult one of our financial secretaries and they will explain to you our monthly payment option - Healthcare Credit and CareCredit which can offer up to 1 year without interest.
- * There are other dental procedures that require multiple or sequential treatment. Crowns and Root Canal therapy are examples to these. For these procedures we ask that a minimum of 50% be paid when treatment has begun, with the remainder paid at completion.
- * If you have dental insurance, we require your coinsurance payment the day of service. Your portion will be estimated using the insurance information we have in our office. If this results in a credit balance, those dollars will be refunded to you at the end of the month. It is important to remember that in all insurance situations, the patient is ultimately responsible for compensating us for our services.
- * A yearly interest rate of 18% (1.5% monthly) will be applied to balances over 30 days.
- * We send statements out as a courtesy to all our patients regardless if a patient has pending insurance or not.

*Broken appointments are a disappointment for everyone. They interfere with dental treatment and cause unnecessary scheduling problems. Therefore, we will make every effort to schedule appointments that are most convenient for you. **CONSEQUENTLY, WE REQUIRE THAT YOU MAKE EVERY EFFORT NOT TO CHANGE YOUR APPOINTMENT TIME ONCE IT IS MADE FOR YOU.** If appointments are missed or changed on short notice, your status as an active patient at our office may change. If appointment changes cannot be avoided, we require 48 hour notice.*

~ We feel these policies provide the fairest possible results for everyone concerned. We appreciate your cooperation. If you have any further questions, please ask. ~

I have read, understood, and agree to the aforementioned office policy:



Signature: _____

Date: _____