© 2012 Wisconsin Dental Association
(800) 243-4675

welcome

PATIENT NUMBER

Patient's Name ______________________
Last First Initial Date of Birth

CIRCLE THE APPROPRIATE ANSWER, IF YOU DON'T KNOW THE CORRECT ANSWER PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION

1. Physician's Name ______
   Address ______
   Tel:( )
2. Are you under a physician's care? . . . . . YES NO
   Since when ______ Why ______
3. When was your last complete physical exam? ______
4. Are you taking any medication or substances? . . . . . YES NO
   (If yes, please list medications in comments section or on the back of this form.)
5. Do you routinely take health related substances? (Vitamins, herbal supplements, natural products) . . YES NO
6. Are you allergic to any medications or substances? (please list) . . . . . YES NO
7. Do you have any other allergies or hives? . . . . . YES NO
8. Do you have any problems with penicillin, antibiotics, anesthetics or other medications? . . . . . YES NO
9. Are you sensitive to any metals or latex? . . . . . YES NO
10. Are you pregnant or suspect you may be? . . . . . YES NO
11. Do you use any birth control medications? . . . . . YES NO
12. Have you ever been treated for or been told you might have heart disease? . . . . . YES NO
13. Do you have a pacemaker, an artificial heart valve implant, or been diagnosed with mitral valve prolapse? . . . . . YES NO
14. Have you ever had rheumatic fever? . . . . . YES NO
15. Are you aware of any heart murmurs? . . . . . YES NO
16. Do you have high or low blood pressure? (please circle) . . . . . YES NO
17. Have you ever had a serious illness or major surgery? . . . . . YES NO
    If so, explain ______
18. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition? . . . . . YES NO
19. Have you ever taken Fosamax, Zometa, Aredia or any other oral or intravenous treatment (bisphosphonates) for bone tumors, excessive calcium in your blood, or osteoporosis? .YES NO
20. Do you have inflammatory diseases, such as arthritis or rheumatism? . . . . . YES NO
21. Do you have any artificial joints/prosthesis? . . . . . YES NO
22. Do you have any blood disorders, such as anemia, leukemia, etc? . . . . . YES NO
23. Have you ever bled excessively after being cut or injured? . . . . . YES NO
24. Do you have any stomach problems? . . . . . YES NO
25. Do you have any kidney problems? . . . . . YES NO
26. Do you have any liver problems? . . . . . YES NO
27. Are you diabetic? . . . . . YES NO
28. Do you have fainting or dizzy spells? . . . . . YES NO
29. Do you have asthma? . . . . . YES NO
30. Do you have epilepsy or seizure disorders? . . . . . YES NO
31. Do you or have you had venereal or any sexually transmitted disease? . . . . . YES NO
32. Have you tested HIV positive? . . . . . YES NO
33. Do you have AIDS? . . . . . YES NO
34. Have you had or do you test positive for hepatitis? . . . . . YES NO
35. Do you or have you had T.B.? . . . . . YES NO
36. Do you smoke, chew, use snuff or any other forms of tobacco? . . . . . YES NO
37. Do you regularly consume more than one or two alcoholic beverages a day? . . . . . YES NO
38. Do you habitually use controlled substances? . . . . . YES NO
39. Have you had psychiatric treatment? . . . . . YES NO
40. Have you taken any prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products? . . . . . YES NO
41. Do you have any disease condition, or problem not listed? If so, explain ______
42. Is there anything else we should know about your health that we have not covered in this form?
43. Would you like to speak to the Doctor privately about any problem? . . . . . YES NO

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE ______ DATE ______

DENTIST'S SIGNATURE ______ DATE ______

ANEST.

MED. ALERT

MEDICAL HISTORY

Form No. T140MH

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welcome

PATIENT NUMBER

Patient's Name ____________________
Last | First | Initial | Date of Birth

COMMENTS

1. Purpose of initial visit ____________________
2. Are you aware of a problem? ____________________
3. How long since your last dental visit? ____________________
4. What was done at that time? ____________________
5. Previous dentist's name ____________________
   Address: ____________________ Tel. ____________________
6. When was the last time your teeth were cleaned? ____________________

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

7. Have you made regular visits? .... YES NO
   How often: ____________________
8. Were dental x-rays taken? .... YES NO
9. Have you lost any teeth or have any teeth been removed? .... YES NO
   Why? ____________________
10. Have they been replaced? .... YES NO
11. How have they been replaced?
    a. Fixed bridge ____________________ Age ____________
    b. Removable bridge ____________________ Age ____________
    c. Denture ____________________ Age ____________
    d. Implant ____________________ Age ____________
12. Are you unhappy with the replacement? .... YES NO
    If yes, explain ____________________
13. Would you like to know about permanent replacements? .... YES NO
14. Have you ever had any problems or complications with previous dental treatment? .... YES NO
    If yes, explain: ____________________
15. Do you clench or grind your teeth? .... YES NO
16. Does your jaw click or pop? .... YES NO
17. Have you experienced any pain or soreness in the muscles or your face or around your ear? .... YES NO
18. Do you have frequent headaches, neckaches or shoulder aches? .... YES NO
19. Does food get caught in your teeth? .... YES NO
20. Are any of your teeth sensitive to: ❒ Hot? ❒ Cold? ❒ Sweets? ❒ Pressure?
21. Do your gums bleed or hurt? .... YES NO
    When? ____________________
22. Do you experience dry mouth? .... YES NO
23. How often do you brush your teeth? ____________ When? ____________
24. Do you use dental floss? .... YES NO
    How often? ____________________
25. Are any of your teeth loose, tipped, shifted or chipped? .... YES NO
26. Are you unhappy with the appearance of your teeth? .... YES NO
27. How do you feel about your teeth in general? ____________________
28. Do you feel your breath is offensive at times? .... YES NO
29. Have you ever had gum treatment or surgery? .... YES NO
    What? ____________________
    Where? ____________________
    When? ____________________
30. Have you had any orthodontic work? ____________________
31. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? ____________________
32. Do you have any questions or concerns? .... YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE ____________________ DATE ____________

DENTIST'S SIGNATURE ____________________ DATE ____________

ANEST.

MED. ALERT

DENTAL HISTORY

Form No. T150DH

Poplar Crossing
DENTAL

William J. Becker DDS
2630 New Sutton Road
Hoffman Estates, IL 60192
847-884-8484 phone 847-884-8486 fax
www.poplardentalcenter.com

EMERGENCY CONTACT INFORMATION

In case of Emergency, who should be notified?______________________________________
Relationship____________________________ Phone: (   ) __________________________
Do you give our office permission to discuss your medical information with family members?
YES____ NO____ If yes, please provide their names and phone numbers below.

May we leave personal information on your answering machine or cell phone?__________________

I hereby authorize Poplar Crossing Dental to release information regarding care tendered. Should an Insurance claim be filled by Poplar Crossing Dental, I authorize payment of benefits to go directly to Polar Crossing Dental. I understand that I will be responsible for any and all charges not covered by my insurance company.

____

Signature Date

Poplar Crossing
DENTAL

William J. Becker DDS
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Hoffman Estates, IL 60192
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CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) ______________________'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives, and other medication necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I have given consent to the doctor's or designated staff use and disclosure of an oral, written, or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment, and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
5. I agree to be responsible for payment of all services rendered on my behalf of my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1 ½ % late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature____ Date___________________

Parent/Responsible Party's Signature________________________ Relationship to Patient____________

Poplar Crossing
DENTAL

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Hoffman Estates, IL 60192
847-884-8484 phone 847-884-8486 fax
www.poplardentalcenter.com

Name:____
Last First M.I.

Date of Birth:___/___/___ Sex:☐ Male ☐ Female SSN:____________________
Mailing Address:____________________ City:______________ State:______ Zip:________
Home Phone: ( )______________ Work : ( )______________ Cell: ( )______________
E-Mail: ____________________ Marital Status: ____________________

Referred By:____
Primary Care Physician:____________________ Phone: ( )______________

PARENT, SPOUSE, OR RESPONSIBLE PARTY (If different from patient)
Name:____
Last First M.I.
Mailing Address:____
Home Phone: ( )______________ Cell : ( )______________

INSURANCE CARRIER INFORMATION
Primary Insurance Carrier:____________________ I.D.#____________________
Policy Holder's Name____________________ Date of Birth____________________
Secondary Insurance Carrier:____________________ Policy Holder Name____________________

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

Name______________ Occupation______________ Employer's Name______________
Address____________________ City______________ __State___ Zip__________
Phone Number____________________

YOU

Name______________ Occupation______________ Employer's Name______________
Address____________________ City______________ __State___ Zip__________
Phone Number____________________ Fax Number____________________

YOUR SPOUSE

Name______________ Occupation______________ Employer's Name______________
Address____________________ City______________ __State___ Zip__________
Phone Number____________________ Fax Number____________________