© 2007 Wisconsin Dental Association
(800) 243-4675

PATIENT NUMBER

welcome

Age________ Date________

Patient's Name________ (Last / First / Initial) Date of Birth________ ❑ Male ❑ Female

If Child: Parent's Name________

How do you wish to be addressed________

Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Minor ❑

Residence - Street________

City________ State____ Zip________

Business Address________

Telephone: Res.________ Bus.________

Fax________ Cell Phone #________

eMail________

Patient/Parent Employed By________

Present Position________

How Long Held________

Spouse/Parent Name________

Spouse Employed By________

Present Position________

How Long Held________

Who is Responsible for this account________

Drivers License No.________

Method of Payment: Insurance ❑ Cash ❑ Credit Card ❑

Purpose of Call________

Other Family Members in this Practice________

____

Whom may we thank for this referral________

Patient/parent Social Security No.________

Spouse/Parent Social Security No.________

Someone to notify in case of emergency not living with you________

____

DENTAL INSURANCE 1ST COVERAGE

Employee Name________ Date of Birth________

Relationship to patient________

Employer Name________ Yrs.________

Name of Insurance Co.________

Address________

____

Telephone________

Program or policy #________

Social Security No.________

Union Local or Group________

DENTAL INSURANCE 2ND COVERAGE

Employee Name________ Date of Birth________

Relationship to patient________

Employer Name________ Yrs.________

Name of Insurance Co.________

Address________

____

Telephone________

Program or policy #________

Social Security No.________

Union Local or Group________

CONSENT:

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

____

____

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.

I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE

X________

DATE________

Form No. T110R

REGISTRATION

Brian T. Tanaka, D.M.D.

welcome

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 INF~~ORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE ______ DATE ______

DENTIST'S SIGNATURE ______ DATE ______

ANEST.

MED. ALERT

DENTAL HISTORY

Form No. T150DH