

MIDWESTERN DENTAL

PATIENT INFORMATION

PATIENT NAME:	() Male	DATE OF BIRTH:
	() Female	
ADDRESS:	CITY:	STATE: ZIP:
HOME PHONE:	WORK PHONE:	S.S.#:
PERSON TO CONTACT IN CASE OF EMERGENCY:		PHONE:
HOW DID YOU HEAR ABOUT US?	DRIVER LICENSE #:	

INSURANCE INFORMATION

If you would like us to submit your claims for services directly to your Dental Insurance Company (Including Midwestern Dental Plans). You must provide information about all dental benefit programs that could cover the patient. If you would prefer to pay for the services yourself and be reimbursed by your Insurance you need not complete this section.

Please print the following information for the person who has the dental insurance:

	Additional Dental Insurance (If covered by)
What dental insurance do you have? _____	
Dental insurance group #: _____	
Dental insurance phone #: _____	
Where do you work? _____	
Work phone number: () _____	() _____
Employee name who has dental insurance: _____	
Date of birth of insurance holder: _____	
Social security number of insurance holder: _____	
Union / Local Number: _____	
Are you hourly or salary? _____	
Are you working or retired? _____	

Who is responsible for this account: _____

SIGNATURE AUTHORIZATION: I hereby authorize Midwestern Dental to execute in my name all payment application forms for treatment. The determination of Midwestern Dental as treatment rendered shall be conclusive. I also authorize Midwestern Dental to sign my name to their computer insurance forms when processing my account for payments.

SIGNATURE OF DENTAL INSURANCE HOLDER	DATE
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FOR OFFICE USE ONLY		
Patient Eligibility: Benefit 1 () YES () NO Date _____	Benefit 2 () YES () NO Date _____	
Person At Insurance Company	M / W Employee Initials	Picture I.D. Verified

MIDWESTERN DENTAL

PATIENT DENTAL HISTORY

PREVIOUS DENTIST: _____	DATE OF LAST DENTAL EXAM: _____			
<p>YES</p> <p><input type="checkbox"/> Are you or have you recently been experiencing pain in your mouth or face?</p> <p><input type="checkbox"/> Do you have any dental condition(s) which you believe requires immediate attention today?</p> <p><input type="checkbox"/> Have you experienced an unusual reaction to a local anesthetic (novocaine)?</p> <p><input type="checkbox"/> Have you ever had abnormal bleeding associated with previous extractions, surgery or accidents?</p> <p>DO YOU HAVE OR USE ANY OF THE FOLLOWING (INDICATE WITH X)</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; vertical-align: top;"> <p>YES</p> <p><input type="checkbox"/> Teeth sensitive to cold, heat sweets or pressure</p> <p><input type="checkbox"/> Bleeding Gums; How Long _____</p> <p><input type="checkbox"/> Food Impaction</p> <p><input type="checkbox"/> Unpleasant taste</p> <p><input type="checkbox"/> Bad breath</p> <p><input type="checkbox"/> Clenching or grinding of teeth</p> </td> <td style="width: 33%; vertical-align: top;"> <p>YES</p> <p><input type="checkbox"/> Frequent blisters on lips or mouth (cold sores)</p> <p><input type="checkbox"/> Swelling or lumps in mouth</p> <p><input type="checkbox"/> Pain around ear</p> <p><input type="checkbox"/> Headaches</p> <p><input type="checkbox"/> Orthodontic treatment</p> <p><input type="checkbox"/> Periodontal treatment (gums)</p> </td> <td style="width: 33%; vertical-align: top;"> <p>YES</p> <p><input type="checkbox"/> Oral habits (fingernail / check biting)</p> <p><input type="checkbox"/> Cigarette, pipe or cigar smoking</p> <p><input type="checkbox"/> Unfavorable dental experience</p> <p><input type="checkbox"/> Jaw clicking / popping</p> <p><input type="checkbox"/> TMJ / Jaw problems</p> </td> </tr> </table>		<p>YES</p> <p><input type="checkbox"/> Teeth sensitive to cold, heat sweets or pressure</p> <p><input type="checkbox"/> Bleeding Gums; How Long _____</p> <p><input type="checkbox"/> Food Impaction</p> <p><input type="checkbox"/> Unpleasant taste</p> <p><input type="checkbox"/> Bad breath</p> <p><input type="checkbox"/> Clenching or grinding of teeth</p>	<p>YES</p> <p><input type="checkbox"/> Frequent blisters on lips or mouth (cold sores)</p> <p><input type="checkbox"/> Swelling or lumps in mouth</p> <p><input type="checkbox"/> Pain around ear</p> <p><input type="checkbox"/> Headaches</p> <p><input type="checkbox"/> Orthodontic treatment</p> <p><input type="checkbox"/> Periodontal treatment (gums)</p>	<p>YES</p> <p><input type="checkbox"/> Oral habits (fingernail / check biting)</p> <p><input type="checkbox"/> Cigarette, pipe or cigar smoking</p> <p><input type="checkbox"/> Unfavorable dental experience</p> <p><input type="checkbox"/> Jaw clicking / popping</p> <p><input type="checkbox"/> TMJ / Jaw problems</p>
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MEDICAL HISTORY

PHYSICIAN'S NAME: _____	CITY: _____	DATE OF LAST PHYSICAL EXAM: _____					
<p>YES</p> <p><input type="checkbox"/> Has there been any recent change in your general health?</p> <p><input type="checkbox"/> Do you take any medications, drugs or pills (including birth control pills)? If yes, please list: _____</p> <p><input type="checkbox"/> Are you being treated for any condition by a physician now? If yes, please explain: _____</p> <p><input type="checkbox"/> Have you been hospitalized during the past two years? If yes, please explain: _____</p> <p><input type="checkbox"/> ARE THERE ANY MEDICATIONS THAT YOU CANNOT TAKE OR ARE ALLERGIC TO OR HAVE HAD A REACTION TO?</p> <p><input type="checkbox"/> PENICILLIN <input type="checkbox"/> CODEINE <input type="checkbox"/> NOVACAINE <input type="checkbox"/> ASPIRIN <input type="checkbox"/> ANESTHETICS <input type="checkbox"/> LATEX <input type="checkbox"/> OTHER _____</p> <p><input type="checkbox"/> Have you ever had a General Anesthetic? List any problems: _____</p> <p><input type="checkbox"/> FOR WOMEN: Are you pregnant? If so, how many months? _____ months Are you breast feeding? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>INDICATE WITH (X) ONLY IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; vertical-align: top;"> <p>YES</p> <p><input type="checkbox"/> Rheumatic Fever</p> <p><input type="checkbox"/> Heart Murmur</p> <p><input type="checkbox"/> Heart Attack</p> <p><input type="checkbox"/> Cardiac Pacemaker</p> <p><input type="checkbox"/> Artificial Heart Valve</p> <p><input type="checkbox"/> Congenital Heart Disease</p> <p><input type="checkbox"/> Mitral Valve Prolapse</p> <p><input type="checkbox"/> Angina / Chest Pain</p> <p><input type="checkbox"/> High / Low Blood Pressure</p> <p><input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> Ankle Swelling</p> <p><input type="checkbox"/> Tire Very Easily</p> <p><input type="checkbox"/> Fainting Spells</p> <p><input type="checkbox"/> Sinus Trouble</p> </td> <td style="width: 33%; vertical-align: top;"> <p>YES</p> <p><input type="checkbox"/> Shortness of Breath</p> <p><input type="checkbox"/> Sickle Cell Trait or Anemia</p> <p><input type="checkbox"/> Bleeding Disorder</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Liver Disease</p> <p><input type="checkbox"/> Dialysis</p> <p><input type="checkbox"/> Hepatitis _____</p> <p><input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> Venereal Disease</p> <p><input type="checkbox"/> AIDS (HIV)</p> <p><input type="checkbox"/> Ulcers or Colitis</p> <p><input type="checkbox"/> Epilepsy or Seizures</p> <p><input type="checkbox"/> Long Disease</p> <p><input type="checkbox"/> Thyroid</p> </td> <td style="width: 33%; vertical-align: top;"> <p>YES</p> <p><input type="checkbox"/> Eye Disorders</p> <p><input type="checkbox"/> Muscular Disease</p> <p><input type="checkbox"/> Head / Spinal Injury</p> <p><input type="checkbox"/> Artificial Joint</p> <p><input type="checkbox"/> Organ Transplant</p> <p><input type="checkbox"/> Hormone Disorder</p> <p><input type="checkbox"/> Genetic Disorder</p> <p><input type="checkbox"/> Steroid Use</p> <p><input type="checkbox"/> Radiation Therapy</p> <p><input type="checkbox"/> Cancer Therapy</p> <p><input type="checkbox"/> Hayfever</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> Other _____</p> </td> </tr> </table> <p>YES NO</p> <p><input type="checkbox"/> <input type="checkbox"/> Is there any health information which was not asked which may influence dental treatment? If yes, please explain _____</p> <p>TO THE BEST OF MY KNOWLEDGE THE FOREGOING QUESTIONS HAVE BEEN ACCURATELY ANSWERED.</p> <table style="width: 100%; border: none; margin-top: 10px;"> <tr> <td style="width: 50%; text-align: center;"> <p>_____ SIGNATURE OF PATIENT / PARENT</p> </td> <td style="width: 50%; text-align: center;"> <p>_____ REVIEWED BY D.D.S.</p> </td> </tr> </table> <p style="text-align: center; font-size: small;">Note: Any change in your health status should be reported to this office at the earliest possible time.</p>			<p>YES</p> <p><input type="checkbox"/> Rheumatic Fever</p> <p><input type="checkbox"/> Heart Murmur</p> <p><input type="checkbox"/> Heart Attack</p> <p><input type="checkbox"/> Cardiac Pacemaker</p> <p><input type="checkbox"/> Artificial Heart Valve</p> <p><input type="checkbox"/> Congenital Heart Disease</p> <p><input type="checkbox"/> Mitral Valve Prolapse</p> <p><input type="checkbox"/> Angina / Chest Pain</p> <p><input type="checkbox"/> High / Low Blood Pressure</p> <p><input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> Ankle Swelling</p> <p><input type="checkbox"/> Tire Very Easily</p> <p><input type="checkbox"/> Fainting Spells</p> <p><input type="checkbox"/> Sinus Trouble</p>	<p>YES</p> <p><input type="checkbox"/> Shortness of Breath</p> <p><input type="checkbox"/> Sickle Cell Trait or Anemia</p> <p><input type="checkbox"/> Bleeding Disorder</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Liver Disease</p> <p><input type="checkbox"/> Dialysis</p> <p><input type="checkbox"/> Hepatitis _____</p> <p><input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> Venereal Disease</p> <p><input type="checkbox"/> AIDS (HIV)</p> <p><input type="checkbox"/> Ulcers or Colitis</p> <p><input type="checkbox"/> Epilepsy or Seizures</p> <p><input type="checkbox"/> Long Disease</p> <p><input type="checkbox"/> Thyroid</p>	<p>YES</p> <p><input type="checkbox"/> Eye Disorders</p> <p><input type="checkbox"/> Muscular Disease</p> <p><input type="checkbox"/> Head / Spinal Injury</p> <p><input type="checkbox"/> Artificial Joint</p> <p><input type="checkbox"/> Organ Transplant</p> <p><input type="checkbox"/> Hormone Disorder</p> <p><input type="checkbox"/> Genetic Disorder</p> <p><input type="checkbox"/> Steroid Use</p> <p><input type="checkbox"/> Radiation Therapy</p> <p><input type="checkbox"/> Cancer Therapy</p> <p><input type="checkbox"/> Hayfever</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> Other _____</p>	<p>_____ SIGNATURE OF PATIENT / PARENT</p>	<p>_____ REVIEWED BY D.D.S.</p>
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PERMISSION TO RELEASE HEALTH INFORMATION: I grant the right to the dentist to release health information about me and information about my dental treatment to third party payors and / or other health practitioners.

_____ SIGNATURE OF PERSON COMPLETING THIS FORM	_____ DATE	_____ IF OTHER THAN PATIENT, INDICATE RELATIONSHIP
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