

PERSONAL INFORMATION

Peterson
Family Dentistry
NATALIE PETERSON, D.D.S.

1. ABOUT YOU

Date _____

Patient Name _____

I prefer to be addressed as _____

(please check) Male Female Child Single Married Widowed
 Divorced Domestic Partnered

Home Address _____

City, Zip _____

Cell No. _____

Home No. _____ Work No. _____ Ext. _____

May we contact you at this work phone? Yes No

Email address(es) _____

How would you prefer to be reminded of appointments? E-mail or
 Phone (indicate preferred number to call) _____

Date of Birth _____

Drivers License No. _____

(note, we cannot take checks from those who do not provide their Drivers License No.)

Employer _____

Occupation _____

Other family and household members at Peterson Family Dentistry _____

Check all the ways you have heard about us

- Previous Patient Home Pages Phone Book
 Peterson Website Insurance Website Lutheran Digest
 Sussex Sun Ad Sussex Chamber of Commerce
 Pick N Save Shopping Carts Outside Sign Referral Card
 Referral from another dentist/patient/staff Dr. Rasch Dr. Ostdick

Referral's dentist/patient/staff Name _____

2. SPOUSE/EMERGENCY INFO

Spouse/Partner _____

Employer _____

Cell No. _____

Work No. _____ Ext. _____

Date of Birth _____

In the event of an emergency, is there someone other than a spouse you would like us to contact?

Name _____

Relation _____

Home No. _____

Cell No. _____

Work No. _____ Ext. _____

3. FINANCIAL INFO

If other than yourself, please list the person responsible for the account and their information below

Name _____

Social Security No. _____

Billing Address _____

Home No. _____

Work No. _____ Ext. _____

Relationship to patient _____

Employer Name _____

4. INSURANCE INFO

Primary Dental Coverage Insurance Co. _____

Insured's Name _____

Date of Birth _____

Member ID No. _____

Do you have Secondary Dental Insurance Coverage?

Yes No

I authorize release of any information relating to claims sent by Peterson Family Dentistry. I wish to assign benefits to Peterson Family Dentistry and understand that I am responsible for any co-payment and deductibles that my insurance does not cover.

Signature _____

Date _____

DENTAL INFORMATION

1. MEETING PATIENT'S IMMEDIATE NEEDS

Patient Name _____

What brings you here today? Check-up Time Problem Other (explain) _____

Why are you changing dental offices? Insurance Location Didn't Like
 Other (explain) _____

Do you have problems with your teeth now? Yes No

If Yes (check) Hot Cold Sweet Food-Caught Broken Tooth Other

2. PAST DENTAL HISTORY

When was the last time you saw a dentist? 1st visit 6 mo. 1 yr. 2 yrs. 3+ yrs.

Former Dentist _____

Clinic-Location _____

Phone No. _____

Last Visit _____

What treatment did you receive? Preventive Basic Fillings Major Restoration

Was that a comfortable experience? Yes No

Why? _____

Did you have any treatment that was recommended but not yet completed? Yes No

If yes _____

3. HOME CARE & PERIO HISTORY

What do you do at home to take care of your oral health?

Brush; How often _____ Floss; How often _____ Mouthwash Yes No

Any bleeding when you brush or floss your teeth? Yes No

Concerned about (check) Bad Breath Taste

Other (explain) _____

4. COSMETIC

Are you happy with your smile? Yes No

Anything you would like to change if you could? Color Shape Position

Detail (if needed) _____

5. FEARS OR ANXIETIES

Is there anything you don't like about dental appointments?

Discomfort Fee Time Inconvenience Afraid Other (explain) _____

6. LIFETIME SMILE PLAN

The way we practice dentistry is something we call "Lifetime Smile Plan." What that means is that we provide you with enough education about the health of your mouth so that you can make choices for yourself. This allows you to save your teeth for the rest of your life, while being happy about the way they LOOK and FEEL.

We are going to teach you about what is HEALTHY and UNHEALTHY, and we will provide you with the alternatives to treating the unhealthy areas. We will inform you of the risks, advantages and disadvantages of treating or not treating your teeth as well. One of the alternatives will always be "TO DO NOTHING." We will always inform you of your costs and what you can expect from your insurance before you schedule your treatment, so there will never be any surprise.

Other Comments _____



HEALTH INFORMATION

1. HEALTH HISTORY

Today's Date _____

Patient Name _____

Patient Date of Birth _____

Personal Physician _____

Clinic-Location _____

Phone No. _____

Please list any medications you are currently taking (include over the counter medicines)

Medications	Reasons
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are you currently taking birth control pills? Yes No

Have you ever taken osteoporosis treatment drugs? Yes No

2. ALLERGIES

Please circle if you have any allergies to the following:

Amoxicillin	Aspirin	Erythromycin	Metals / Jewelry	Sulfa
Anesthetics	Codeine	Latex	Penicillin	Tetracycline

Other (explain) _____

(If any circled) please describe symptoms: _____

3. CONDITIONS

Please circle if you have ever had any of the following diseases or medical conditions.

- Alzheimer's / Memory Loss
- Anemia
- Anorexia / Bulimia
- Arthritis
- Artificial Joints (Date _____)
- Artificial Heart Valves
- Asthma / Hay Fever
- Blood Transfusions
- Cancer / Chemotherapy
- Cold Sores / Herpes
- Congenital Heart Defect
- Diabetes
- Difficulty Breathing
- Drug / Alcohol Abuse
- Emphysema
- Epilepsy / Seizures / Fainting
- Gastrointestinal Disorder / Acid Reflux
- Glaucoma (Narrow Angle)
- Headaches (Severe, Frequent)
- Hearing Impaired
- Heart Attack
- Heart Murmur
- Heart Surgery
- Hemophilia / Abnormal Bleeding
- Hepatitis A B C D
- High / Low Blood Pressure
- HIV / AIDS
- Liver Disease
- Kidney Problems
- Migraines
- Mitral Valve Prolapse
- Pacemaker
- Radiation Treatments
- Rheumatic / Scarlet Fever
- Shingles
- Smoking / Tobacco
- Sinus Problems
- Stents Placed in Heart (Date _____)
- Stroke
- Snoring / Sleep Apnea
- Thyroid problems
- Tuberculosis
- Tumor Growth
- Venereal Disease
- Other / Surgeries

Have you ever been told you need antibiotics before a dentist appointment? Yes No

Are you pregnant? Yes No

Are you currently nursing? Yes No

Would you like to speak privately with the Doctor about any problems?
 Yes No

I hereby certify that the information I have given here today is correct to the best of my knowledge and that payment is due in full at the time of treatment unless prior arrangements have been approved. Furthermore I understand that a 24 hour notice is required to change appointments.

Signature _____ Date _____