Michelle Lamers DDS
711 S 76th St,
Franklin, WI 53132

WELCOME

PATIENT INFORMATION

Date _____
SS/HIC/Patient ID # _____
Patient Name _____
Address _____
City _____
State _____ Zip _____
E-mail _____
Sex _____
Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ Years

Occupation _____
Patient Employer/School _____
Employer/School Address _____
_____
Employer/School Phone _____
Spouse's Name _____
Birthdate _____
SS# _____
Spouses Employer _____

Whom may we thank for referring you?
_____

DENTAL INSURANCE

Who is responsible for this account? _____
Relationship to Patient _____
Insurance Co. _____
Group # _____
Is the patient covered by additional insurance? _____
Subscriber's Name _____
Birthdate _____ SS# _____
Relationship to Patient _____
Insurance Co. _____
Group# _____

ASSIGNMENT AND RELEASE

I certify that I and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. _____ All insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insutance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my currenr treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to patient

PHONE NUMBERS

Home _____ Work _____ Ext _____ Cell Phone _____
Spouse's Work _____ Best time and place to reach you _____

IN CASE OF EMERGENCY CONTACT (Specify someone who does not live in tour household.)

Name _____ Relationship _____
Home Phone _____ Work Phone _____

DENTAL HISTORY

Reason for todays visit _____
_____
Former Dentist _____
City/State _____
Date of last dental visit _____
Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you've had any of the following

Bad breath	☐Yes	☐No	Burning sensation on tongue	☐Yes	☐No	Mouth pain, brushing	☐Yes	☐No
Bleeding gums	☐Yes	☐No	Chew on one side of the mouth	☐Yes	☐No	Orthogontic treatment	☐Yes	☐No
Blistering on lips or mouth	☐Yes	☐No	Cigarette, pipe, or cigar smoking	☐Yes	☐No	Pain around ear	☐Yes	☐No
			Clicking or popping jaw	☐Yes	☐No	Periodontal treatment	☐Yes	☐No
			Dry mouth	☐Yes	☐No	Sensitivity to cold	☐Yes	☐No
			Fingernail biting	☐Yes	☐No	Sensitivity to heat	☐Yes	☐No
			Food collection between teeth	☐Yes	☐No	Sensitivity to sweets	☐Yes	☐No
			Foreign objects	☐Yes	☐No	Sensitivity when biting	☐Yes	☐No
			Grinding teeth	☐Yes	☐No	Sores or growths in your mouth	☐Yes	☐No
			Gums swollen or tender	☐Yes	☐No			
			Jaw pain or tiredness	☐Yes	☐No			
			Lip or cheek biting	☐Yes	☐No			
			Loose teeth or broken fillings	☐Yes	☐No			
			Mouth breathing	☐Yes	☐No			

How oftenn do you floss? _____
_____
How often do you brush? _____
_____

Health History

Physician's Name _____ Date of last visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐Yes ☐No

Have you ever taken any of the group of drugs referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand name of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐Yes	☐No	Epilepsy	☐Yes	☐No	Respiratory disease	☐Yes	☐No
Anemia	☐Yes	☐No	Fainting or dizziness	☐Yes	☐No	Rheumatic fever	☐Yes	☐No
Arthritis, Rheumatism	☐Yes	☐No	Glaucoma	☐Yes	☐No	Scarlet fever	☐Yes	☐No
Artificial Heart Valves	☐Yes	☐No	Headaches	☐Yes	☐No	Shortness of breath	☐Yes	☐No
Artificial joints	☐Yes	☐No	Heart Murmur	☐Yes	☐No	Sinus trouble	☐Yes	☐No
Asthma	☐Yes	☐No	Heart problems	☐Yes	☐No	Skin rash	☐Yes	☐No
Back problems	☐Yes	☐No	Hepatitis type	☐Yes	☐No	Special diet	☐Yes	☐No
Bleeding abnormally, with extractions or surgery	☐Yes	☐No	Herpes	☐Yes	☐No	Stroke	☐Yes	☐No
			High blood pressure	☐Yes	☐No	Swollen feet or ankles	☐Yes	☐No
Blood disease	☐Yes	☐No	Jaundice	☐Yes	☐No	Swollen neck glands	☐Yes	☐No
Cancer	☐Yes	☐No	Jaw pain	☐Yes	☐No	Thyroid problems	☐Yes	☐No
Chemical dependency	☐Yes	☐No	Kidney disease	☐Yes	☐No	Tonsillitis	☐Yes	☐No
Chemotherapy	☐Yes	☐No	Low blood pressure	☐Yes	☐No	Tuberculosis	☐Yes	☐No
Circulatory problems	☐Yes	☐No	Mitral Valve Prolapse	☐Yes	☐No	Tumor or growth on head or neck	☐Yes	☐No
Congenital Heart problems	☐Yes	☐No	Nervous problems	☐Yes	☐No			
Cortisone treatments	☐Yes	☐No	Pacemaker	☐Yes	☐No	Ulcer	☐Yes	☐No
Cough, persistent or bloody	☐Yes	☐No	Psychiatric care	☐Yes	☐No	Venereal disease	☐Yes	☐No
Diabetes	☐Yes	☐No	Radiation treatment	☐Yes	☐No	Weightloss, unexplained	☐Yes	☐No
Emphysema	☐Yes	☐No						

Do you wear contact lenes? ☐Yes ☐No

Women:

Are you pregnant? ☐Yes ☐No Due Date _____ Are you nursing? ☐Yes ☐No

Taking birth control pills? ☐Yes ☐No

Medications

List any medications you are currently taking and the correlating diagnosis: _____

_____

_____

Pharmacy Name _____

Phone _____

Allergies

☐Aspirin ☐Local Anesthetic

☐Barbiturates (Sleeping pills) ☐Penicillin

☐Codeine ☐Sulfa

☐Iodine ☐Other _____

☐Latex _____

Updates (To be filled in at future appointments)

Has there been any changed in your health since your last dental appointment? ☐Yes ☐ No

For what conditions?

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Has there been any changed in your health since your last dental appointment? ☐Yes ☐ No

For what conditions?

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____