

**Willmar Family Dentistry, P.A.**  
1016 1<sup>st</sup> Street S / Willmar MN 56201  
Phone: 320-235-2010 / Fax: 320-235-7133

**Welcome!** The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain optimal oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

**Patient Information:**

Name: \_\_\_\_\_  Mr.  Mrs.  Ms.  Dr. Nickname: \_\_\_\_\_

Home Address: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

City / State / Zip: \_\_\_\_\_ SS#: \_\_\_\_\_

Hm#: \_\_\_\_\_ Wk# \_\_\_\_\_ Cell#: \_\_\_\_\_

Single  Married  Divorced/Separated  Widowed DL#: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ How long there? \_\_\_\_\_

Where/when are the best times to reach you? \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Other family members seen by us: \_\_\_\_\_ Previous Dentist: \_\_\_\_\_

**Spouse Information:** His / Her Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Employer: \_\_\_\_\_ Wk#: \_\_\_\_\_

**Insurance Information:** Dental Coverage?  Yes  No

Insurance Co. Name: \_\_\_\_\_ Ph#: \_\_\_\_\_

Address: \_\_\_\_\_ Group #: \_\_\_\_\_

City / State / Zip: \_\_\_\_\_ Insured's Employer: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Insured's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured's SS#: \_\_\_\_\_

**Secondary Insurance:** Dental Coverage?  Yes  No

Insurance Co. Name: \_\_\_\_\_ Ph#: \_\_\_\_\_

Address: \_\_\_\_\_ Group #: \_\_\_\_\_

City / State / Zip: \_\_\_\_\_ Insured's Employer: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Insured's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured's SS#: \_\_\_\_\_

**Medical History:**

Do you have a personal physician?  Yes  No Physician's Name: \_\_\_\_\_

Physician's Ph#: \_\_\_\_\_ Last Visit: \_\_\_\_\_

Your current physical health is:  Good  Fair  Poor

Are you currently under the care of a physician?  Yes  No Please explain: \_\_\_\_\_

Do you smoke or use tobacco in any other form?  Yes  No

Have you had any metal rods, pins, or implants?  Yes  No

Are you taking any prescription / over-the-counter drugs?  Yes  No Please list: \_\_\_\_\_

Have you ever taken Phen-Fen (aka Redux or Pondimin)?  Yes  No If so, when? \_\_\_\_\_

Have you ever had any of the following diseases or medical problems?

- |  |                                 |                                |
|--|---------------------------------|--------------------------------|
| Y N Abnormal Bleeding / Hemophilia     | Y N Fainting Spells             | Y N Mitral Valve Prolapse      |
| Y N AIDS                               | Y N Frequent Headaches          | Y N Pacemaker                  |
| Y N Alcohol / Drug Abuse               | Y N Glaucoma                    | Y N Psychiatric Problems       |
| Y N Anemia                             | Y N Hay Fever                   | Y N Radiation Treatment        |
| Y N Arthritis                          | Y N Heart Attack / Surgery      | Y N Rheumatic / Scarlet Fever  |
| Y N Artificial Bones / Joints / Valves | Y N Heart Murmur                | Y N Seizures                   |
| Y N Asthma                             | Y N Hepatitis A / B / C         | Y N Shingles                   |
| Y N Blood Transfusion                  | Y N Herpes / Fever Blisters     | Y N Sickle Cell Disease/Traits |
| Y N Cancer / Chemotherapy              | Y N High Blood Pressure         | Y N Sinus Problems             |
| Y N Colitis                            | Y N HIV                         | Y N Stroke                     |
| Y N Congenital Heart Defect            | Y N Hospitalized for any reason | Y N Thyroid Problems           |
| Y N Diabetes                           | Y N Kidney Problem              | Y N Tuberculosis (TB)          |
| Y N Difficulty Breathing               | Y N Liver Disease               | Y N Ulcers                     |
| Y N Emphysema                          | Y N Low Blood Pressure          | Y N Venereal Disease           |
| Y N Epilepsy                           | Y N Lupus                       |                                |

Please list any serious medical condition(s) that you have ever had: \_\_\_\_\_

Are you allergic to any of the following?

- |                        |                      |                  |
|------------------------|----------------------|------------------|
| Y N Aspirin            | Y N Erythromycin     | Y N Penicillin   |
| Y N Codeine            | Y N Jewelry / Metals | Y N Tetracycline |
| Y N Dental Anesthetics | Y N Latex            | Y N Other _____  |

Please list any other drugs/materials that you are allergic to: \_\_\_\_\_

**For women:** Are you taking birth control pills?  Yes  No Are you pregnant?  Yes  No Are you nursing?  Yes  No

**Dental History:**

Why have you scheduled this dental appointment? \_\_\_\_\_

- Are you currently in pain?  Yes  No
- Do you require antibiotics before dental treatment?  Yes  No
- Your current dental health is:  Good  Fair  Poor
- Have you ever had a serious / difficult problem associated with any previous dental work?  Yes  No
- Do you floss daily?  Yes  No
- Do you brush daily?  Yes  No
- Are the bristles on your toothbrush  Hard  Medium  Soft
- Do your gums ever bleed or itch?  Yes  No
- Have you ever had periodontal disease?  Yes  No
- Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)?  Yes  No
- Are your teeth sensitive to heat, cold, or anything else?  Yes  No
- Do you have mobility in your teeth?  Yes  No
- Do you still have your wisdom teeth?  Yes  No
- Would you like fresher breath?  Yes  No Whiter teeth?  Yes  No
- Are you happy with the way your smile looks?  Yes  No If not, what would you change? \_\_\_\_\_

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Patient / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Payment is due in full at the time of treatment** unless prior arrangements have been approved. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Patient / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_