# *Willmar Family Dentistry, P.A.*

*1016 First St S / Willmar MN 56201 / Ph: 320-235-2010 / Fx: 320-235-7133 / www.willmardentist.com*

***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: ______________________
Last First MI

Home Address: ______________________________________________________________ Birthdate: ______ / ______ / ______

City / State / Zip: ________________________________________________ SSN: ______________________________________

Hm#: ______________________________ Wk# ______________________________ Cell#: ______________________________

☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed

Employer: _______________________________________ Occupation: ________________________ How long there? ________

Where/when are the best times to reach you? _______________________________________________________________________

How did you hear about us? _________________________________ E-Mail: ___________________________________________

Other family members seen by us: ___________________________________ Previous Dentist: ______________________________

**Spouse Information:** His / Her Name: ___________________________________________ SSN: ______________________________

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 SSN/ID#: ____________________________________________________

**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 SSN/ID#: ____________________________________________________

**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 Please explain: ________________________

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 medication for osteoporosis? ☐ Yes ☐ No If so, when? ___________________________________

Are you on a low-dose aspirin therapy regimen? ☐ Yes ☐ No

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

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

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:**

When was your last dental appointment? ________________ Reason: ____________________

Why have you scheduled this dental appointment? □ Routine check up □ Other: ____________________

Your current dental health is: □ Good □ Fair □ Poor

Are you currently in pain? □ Yes □ No

Do you require antibiotic premedication before dental treatment? □ Yes □ No

Have you ever had a serious problem 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

Have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? □ Yes □ No

Are your teeth sensitive to heat, cold, sweets, or anything else? □ Yes □ No

Do you have mobility in your teeth? (Do they wiggle?) □ 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.

**Payment is due in full at the time of treatment**. 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 understand it is not the responsibility of this Dental Office to know the details of my insurance plan or to keep track of my benefits. 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: ______________