DENTAL INFORMATION

How long since your last dental Xrays were taken? _____

How long since your last Dental Exam? _____ Main reason for visit today? _____

Previous Dentist _____ Address _____

Have you ever had any serious problems associated with previous Dental Treatment? _____

Pharmacy Name _____ Pharmacy Phone # _____

Does Dental Treatment make you nervous? No ☐ Slightly ☐ Moderately ☐ Extremely ☐

How do you rate the current health of your mouth? Excellent ○ Good ○ Fair ○ Poor ○

On a scale of 1-10 (10 being the highest), what priority do you put on the health of your mouth? ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

Are you happy with the appearance of your teeth? _____

Have you ever had

Past	Present	Never		Past	Present	Never	
○	○	○	Frequent blisters / cold sores	○	○	○	Sensitivity to cold
○	○	○	Food trapping	○	○	○	Sensitivity to hot
○	○	○	Swelling or lump in mouth	○	○	○	Sensitivity to sweets
○	○	○	Clicking / popping jaw	○	○	○	Sensitivity to biting
○	○	○	Clenching / grinding of teeth	○	○	○	Loose teeth
○	○	○	Discomfort in jaw joint	○	○	○	Periodontic Treatment
○	○	○	Recurrent earaches or headaches	○	○	○	Bleeding or sore gums
○	○	○	Orthodontics (Braces)	○	○	○	Unpleasant taste / bad breath
			Treatment Completed _____ Year	○	○	○	Acid Reflux
○	○	○	Bite Plate or Guard	○	○	○	Oral Surgery
				○	○	○	Serious injury to mouth or head

Do you use the following?

	Yes	No	How Often?		Yes	No	How Often?
Brush	○	○	_____	Fluoride rinse	○	○	_____
Floss	○	○	_____	Mouthwash	○	○	_____
Irrigator (Water Pick)	○	○	_____	Tooth picks (Stimudent)	○	○	_____

Is there anything else about your mouth that you would like us to know about? _____

Infant/Toddler Questionnaire

Does your child take a bottle/sippy cup to bed at bedtime or naptime? ○Yes ○No

What kind of toothpaste does your child use? _____

Does it have fluoride in it? ○ Yes ○ No

Does your child spit out the toothpaste? ○Yes ○No

Does your child have any oral habits?

Does your child swallow the toothpaste? ○Yes ○No

Thumb/finger sucking ○ Yes ○ No Pacifier Yes ○ No ○ Other

Was your child breast fed? ○Yes ○No

Was your child bottle fed? ○Yes ○No

At what age was he/she weaned to solid foods _____

Child Questionnaire

When does your child brush his/her teeth? Upon Arising ☐ After meals ☐ Before going to bed ☐

How does your child receive fluoride? Community water ☐ ppm ☐ Fluoride drops/tablets ☐

Well water ☐ ppm ☐ Fluoride toothpaste/rinse/gel ☐

Does your child eat between meals? ○Yes ○No

Does your child eat sweets, such as candy, soda, or chewing gum? ○ Yes ○ No

Does your child have a history of tooth decay? ○Yes ○No

Has your child had any injuries to his/her teeth, resulting in fractures, sensitivity, or discoloration? ○Yes ○No

Has your child had any or the following dental treatment done in the past? Sealants ☐ Fillings ☐ Extractions ☐

Has your child had any behavioral problems with past dental treatment? ○Yes ○No

How do you think your child will behave today? _____

Is there anything else about your child's teeth/mouth that you'd like us to know about? _____

Additional medical questions

Does your child have enlarged tonsils? ○Yes ○No

Is your child a mouthbreather? ○Yes ○No

Does your child have an allergy to latex? ○Yes ○No

Does your child have ADHD? ○Yes ○No

DENTAL PROFESSIONALS

Date _____

MEDICAL HISTORY

for

Name _____ DOB _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a medical doctor's care now? ☐ Yes ☐ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No _____

Are you on a special diet? ☐ Yes ☐ No _____

Do you use tobacco? ☐ Yes ☐ No

Do you use controlled substances? ☐ Yes ☐ No

Women: Are you

Pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	☐ Yes ☐ No	Cortisone Medicine	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Renal Dialysis	☐ Yes ☐ No
Alzheimer's Disease	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Hepatitis A	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Anaphylaxis	☐ Yes ☐ No	Drug Addiction	☐ Yes ☐ No	Hepatitis B or C	☐ Yes ☐ No	Rheumatism	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Easily Winded	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Shingles	☐ Yes ☐ No
Arthritis/Gout	☐ Yes ☐ No	Epilepsy or Seizures	☐ Yes ☐ No	Hives or Rash	☐ Yes ☐ No	Sickle Cell Disease	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Excessive Bleeding	☐ Yes ☐ No	Hypoglycemia	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Artificial Joint	☐ Yes ☐ No	Excessive Thirst	☐ Yes ☐ No	Irregular Heartbeat	☐ Yes ☐ No	Spina Bifida	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Fainting Spells/Dizziness	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No	Stomach/Intestinal Disease	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Frequent Cough	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	Frequent Diarrhea	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Swelling of Limbs	☐ Yes ☐ No
Breathing Problem	☐ Yes ☐ No	Frequent Headaches	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Bruise Easily	☐ Yes ☐ No	Genital Herpes	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Hay Fever	☐ Yes ☐ No	Pain in Jaw Joints	☐ Yes ☐ No	Tumors or Growths	☐ Yes ☐ No
Chest Pains	☐ Yes ☐ No	Heart Attack/Failure	☐ Yes ☐ No	Parathyroid Disease	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Cold Sores/Fever Blisters	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Congenital Heart Disorder	☐ Yes ☐ No	Heart Pace Maker	☐ Yes ☐ No	Radiation Treatments	☐ Yes ☐ No	Yellow Jaundice	☐ Yes ☐ No
Convulsions	☐ Yes ☐ No	Heart Trouble/Disease	☐ Yes ☐ No	Recent Weight Loss	☐ Yes ☐ No		

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

PATIENT REGISTRATION

DATE _____

Patient Information

First Name _____ Middle Initial _____ Last Name _____

Address _____ Preferred Name _____

City, State, Zip _____ E-Mail _____

Hm Phone# _____ Wk Phone# _____ Cell Phone# _____

Date of Birth _____ Social Security # _____ Drivers Lic # _____

Sex: ○ Male ○ Female

Responsible Party

First Name _____ Middle Initial _____ Last Name _____

Address _____ Sex: ○ Male ○ Female

City, State, Zip _____ E-Mail _____

Hm Phone# _____ Wk Phone# _____ Cell Phone# _____

Date of Birth _____ Social Security # _____ Drivers Lic # _____

Marital Status: ○ Married ○ Single ○ Divorced ○ Widowed

Spouses Name _____

Hm Phone# _____ Wk Phone# _____ Cell Phone# _____

Date of Birth _____ Social Security # _____ Drivers Lic # _____

Primary Insurance Information

Name of Insured _____ Social Security# _____ Date of Birth _____

Patient relationship to Insured: Self Spouse Child Other

Employer Name _____ Insurance Co. Name _____

Address _____ Address _____

City, State, Zip _____ City, State, Zip _____

GROUP # _____ **MEMBER ID#** _____

Secondary Insurance Information

Name of Insured _____ Social Security# _____ Date of Birth _____

Patient relationship to Insured: Self Spouse Child Other

Employer Name _____ Insurance Co. Name _____

Address _____ Address _____

City, State, Zip _____ City, State, Zip _____

GROUP # _____ **MEMBER ID#** _____

Emergency Contact: **NOT LIVING IN SAME HOUSE**

Name _____

Phone # _____ Relationship to Patient _____

How did you choose Dental Professionals? _____

If by referral, who can we thank? _____

SIGNATURE ON FILE

1. HEALTH UPDATE – I understand it is my responsibility to inform my dental healthcare provider of any and all health/medical or medication changes since my last visit. (Your signature at the bottom of the page will acknowledge your update.)

2. MINOR CHILD TREATMENT RELEASE – I give permission to Dr. Thomas Albiero, Dr. Keith Templin, Dr. Cynthia Jakusz, Dr. Chad Zambon, Dr. Kyle Menne and/or their designated assistant or hygienist to perform any and all dental techniques and procedures including the administration of dental anesthetics on my minor child(ren), whether or not I am present at the actual appointment when the treatment is rendered. (Your signature at the bottom of the page is permission for release of treatment.)

3. HIPAA – The Health Insurance Portability and Accountability Act (HIPAA) are now in effect as required by the Federal Government. A copy of our Privacy Policy is available for you to read if you choose to. We will also provide you with your own copy if you would like one. (Your signature at the bottom of the page will acknowledge the receipt of notice of privacy practices.)

4. INFORMATION RELEASE – I authorize the release of any information necessary to hospitals, doctors offices, dental offices, and/or to file claims for insurance benefits or a means of recovering fees. (Your signature at the bottom of the page will allow us to share without a signature on each individual form.)

5. INSURANCE AUTHORIZATION – I assign directly to Dr. Thomas Albiero, Dr. Keith Templin, Dr. Cynthia Jakusz, Dr. Chad Zambon and Dr. Kyle Menne dental insurance benefits paid for services rendered. I understand that I am financially responsible for all fees incurred. (Your signature at the bottom of the page allows assignment.)

6. FINANCIAL POLICY – The best dental care can only be maintained through complete understanding of both the dental care required, and the financial arrangements for that care. Our dental office personnel have been trained to assist you with any question that may arise in these areas:

   METHOD OF PAYMENTS: Payment will be discussed at each visit.

   The options we offer are:

   1. Payment at time of service. We offer a 5% discount on cash payment or 3% on credit card payment. Account balance must be cleared at time of visit to qualify.

   2. We accept MasterCard, Visa, Discover or American Express.

   3. We also offer several commercial financial options so that you may have the dental treatment you need.

   DENTAL INSURANCE: Insurance may cover cost of some of your charges. As a service to you, we will submit claims to your insurance company for you but you are ultimately responsible for the entire bill. Since insurance may not cover the entire cost of your service, you are asked to make regular monthly payments to clear any balance within 90 days. Our staff will be happy to assist you in calculating this estimated amount. Should there be an overpayment in the final analysis; the refund will be made directly to you. It is necessary that you provide us with accurate insurance information. You may also be asked in some cases to check with your insurance company on coverage or payment irregularity.

   ACCOUNTS: We do not become involved in domestic matters. The parent accompanying any minor will ultimately be held responsible for the account. We will send one bill for services and do not divide account balances. We will help track personal payments to the best of our ability and send reports upon request.

   LATE PAYMENT CHARGES: A service charge of 1.5% per month will be added to all accounts 90 days or older. Should you have any questions about your statement, please call the office, we will make every effort to answer and resolve any problems.

   MISSED APPOINTMENT FEE: If there is a need to cancel or reschedule an appointment, this must be done at least 48 hours prior to the appointment time. Appointments missed or cancelled less than 48 hours in advance will be bill to you at a standard rate of $50 per appointment. Insurance will not cover missed appointments. *We reserve the right to charge up to $100 per hour scheduled. (Your signature at the bottom of this page acknowledges your agreement to our financial policy.)

AGREEMENT SIGNATURE _____ DATE _____

PRINTED NAME _____

02/2018

DENTAL PROFESSIONALS

Thomas Albiero D.D.S. ◆ Keith Templin D.D.S. ◆ Cynthia Jakusz D.D.S.
restorative and cosmetic dentistry

Chad Zambon D.D.S. ◆ Kyle Menne D.D.S.
specializing in children and adolescents

Previous Dentist's Name _____

Address _____

City, State, Zip _____

Phone _____

Please forward all current bitewing films, full mouth films and/or panoramic films for

_____.
(Please print patient name)

Please send original films, if possible. *If not sending original films, please label x-rays Right or Left side.*

We are capable of accepting electronic transfer of films.
Please e-mail these to: tjohnson@dentalprofessionals.org.

Thank you,

DENTAL PROFESSIONALS
Thomas Albiero, D.D.S.
Keith Templin, D.D.S.
Cynthia Jakusz, D.D.S.
Chad Zambon, D.D.S.
Kyle Menne, D.D.S.

I, _____, authorize the release of all current x-rays to **DENTAL PROFESSIONALS.**

_____ _____
Signature Date

N112 W16760 MEQUON ROAD ◆ GERMANTOWN, WI 53022
PHONE 262-255-7820 FAX 262-255-9969 www.dentalprofessionals.org