# Family Tree Dentistry

## Patient Info, History & Consent Form

## PATIENT INFORMATION

LAST NAME: ______ FIRST NAME: ______ MI: ______

STATUS: ☐ MARRIED ☐ SINGLE ☐ MINOR GENDER: ☐ MALE ☐ FEMALE

ADDRESS: ______ (STREET) ______ (APT #) CITY: ______ STATE: ______ ZIP: ______

HOME PHONE: ______ CELL PHONE: ______ WORK PHONE/OTHER PHONE: ______

BIRTHDAY: ___ / ___ / ___ (MONTH DAY YEAR) SS#: ___ – ___ – ___ EMAIL: ______

## PREFERRED COMMUNICATION METHOD

SELECT BEST METHOD: ☐ HOME PHONE ☐ CELL PHONE ☐ WORK PHONE ☐ TEXT ☐ EMAIL

IF A PHONE NUMBER IS PREFERRED, MAY WE LEAVE PATIENT TREATMENT INFORMATION ON A VOICEMAIL MESSAGE?

SELECT YES OR NO: ☐ YES ☐ NO

MAY WE LEAVE A MESSAGE WITH SOMEONE ELSE AT THE PREFERRED PHONE#?

SELECT YES OR NO: ☐ YES ☐ NO

HAS ANY MEMBER OF YOUR FAMILY BEEN TREATED IN OUR OFFICE

SELECT YES OR NO: ☐ YES ☐ NO IF YES, WHOM: ______

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE

REFERENCE NAME: ______

DID YOU FIND US BY ANOTHER METHOD?

SELECT ANY THAT APPLY: ☐ FTD WEBSITE ☐ INTERNET SEARCH ☐ AD ☐ INSURANCE WEBSITE ☐ DRIVING BY

## FAMILY INFORMATION

RESPONSIBLE PARTY OR INSURANCE CARRIER

SELECT ONE: ☐ SELF ☐ SPOUSE ☐ MOTHER ☐ FATHER ☐ GUARDIAN BIRTHDATE: ___ / ___ / ___ (MONTH DAY YEAR)

LAST NAME: ______ FIRST NAME: ______ MI: ______

ADDRESS: ______ (STREET) ______ (APT #) CITY: ______ STATE: ______ ZIP: ______

INSURANCE COMPANY: ______ GROUP#: ______

## DENTAL HISTORY

WHAT MAY WE DO FOR YOU? ______

DO YOU HAVE DENTAL EXAMINATIONS ON A ROUTINE BASIS?

SELECT YES OR NO: ☐ YES ☐ NO LAST VISIT: ______

IF YOU CHANGE YOUR TEETH/SMILE, WHAT WOULD YOU CHANGE? ______

WHAT WOULD YOU LIKE YOUR TEETH TO BE LIKE IN 20 YEARS? ______

DO YOU GRIND YOUR TEETH?

SELECT YES OR NO: ☐ YES ☐ NO

DOES YOUR JAW CLICK OR POP?

SELECT YES OR NO: ☐ YES ☐ NO

DO YOUR GUMS BLEED?

SELECT YES OR NO: ☐ YES ☐ NO

DO YOU USE TOBACCO?

SELECT YES OR NO: ☐ YES ☐ NO

## MEDICAL HISTORY

ARE YOU CURRENTLY UNDER A PHYSICIAN'S CARE?

SELECT YES OR NO: ☐ YES ☐ NO WHO?: ______ WHY?: ______

HAVE YOU EVER BEEN HOSPITALIZED OR HAD A MAJOR OPERATION? ______

HAVE YOU EVER HAD A SERIOUS INJURY TO YOUR HEAD OR NECK? ______

ARE YOU ON A SPECIAL DIET? SELECT YES OR NO: ☐ YES ☐ NO IF YES, WHAT?: ______

ARE YOU ALERGIC TO ANY MEDICATION?

SELECT ANY THAT APPLY: ☐ ASPIRIN ☐ PENICILLIN ☐ CODEINE ☐ ACRYLIC ☐ LATEX ☐ METAL

WOMEN: PLEASE SELECT ANY THAT APPLY: ☐ PREGNANT ☐ TAKING ORAL CONTRACEPTIVE

HAVE YOU EVER HAD, OR ARE YOU CURRENTLY EXPERIENCING, ANY OF THE FOLLOWING: ( CHECK ANY THAT APPLY )

| | | | |
|---|---|---|---|
| ☐ Heart Trouble/Disease | ☐ Asthma | ☐ Hepatitus A,B,C | ☐ Hemophilia |
| ☐ Mitral Valve Prolapse | ☐ Lung Disease | ☐ HIV | ☐ Lukemia |
| ☐ Artificial Heart Valve | ☐ Breathing Problem | ☐ Drug Addiction | ☐ Recent Blood Transfusion |
| ☐ Heart Surgury | ☐ Emphysema | ☐ High Blood Pressure | ☐ Epilepsy or Seizures |
| ☐ Kidney Problems | ☐ Tuberculosis | ☐ Stroke | ☐ Fainting or Dizziness |
| ☐ Thyroid Disease | ☐ Cancer/Cancer Treatments | ☐ Blood Disease | ☐ Glaucoma |
| ☐ Arthritis/Gout | ☐ Diabetes | ☐ Bruise Easily/Anemia | ☐ Alzheimer's Disease |
| ☐ Cortisone Medicine | ☐ Hypoglycemia | ☐ Excessive Bleeding | ☐ Allergies ( Pollen/Dust ) |
| ☐ Sinus Trouble | ☐ Liver Disease | ☐ Sickle Cell Disease | ☐ Mental/Emotional Impairment |

HAVE YOU HAD A SERIOUS DISEASE NOT MENTIONED ABOVE?

SELECT ANY THAT APPLY: ☐ YES ☐ NO IF YES, WHAT DISEASE?: ______

EMERGENCY CONTACT: ______ PHONE: ______

To the best of my knowledge, all the preceding answers are correct.

X: ______ TODAYS DATE: / /

PATIENT SIGNATURE ( PARENT OR GUARDIAN )

REVIEWED BY PROVIDER: ______ DATE: / /

# Family Tree Dentistry

## Current Medication List

FAMILY TREE
DENTISTRY

## MEDICATION INFORMATION

LAST NAME: ______________________ FIRST NAME: ______________________ MI: ______

ARE YOU TAKING ANY PRESCRIPTION MEDICATIONS, OVER THE COUNTER MEDICATIONS, VITAMINS, NATURAL, HERBAL AND/OR DIETARY SUPPLEMENTS?

SELECT YES OR NO: ☐ YES ☐ NO

| PLEASE LIST ALL MEDICATIONS | REASON TAKING | HOW MUCH | HOW OFTEN |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

X: ______________________________ TODAYS DATE: ____/____/____

PATIENT SIGNATURE ( PARENT OR GUARDIAN )

# Family Tree Dentistry

## Patient Acknowledgement of Receipt of Notice of Privacy Practices

## PATIENT ACKNOWLEDGEMENT

LAST NAME: ______________________ FIRST NAME: ______________________ MI: ____

PATIENT REPRESENTATIVE (IF MINOR): ______________________________________

**I have received (or have been offered) a copy of this office's Notice of Privacy Practices.**

**By signing this form, you are giving this office your consent to use and disclose health information about you for treatment, payment, and health care operation purposes.**

X: ______________________________________ DATE: ____ / ____ / ____

PATIENT SIGNATURE ( PARENT OR GUARDIAN )

WITNESS: ______________________________________

## FOR OFFICE USE ONLY

WE ATTEMPTED TO OBTAIN WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES, BUT ACKNOWLEDGEMENT COULD NOT BE OBTAINED BECAUSE:

- ☐ **INDIVIDUAL REFUSED TO SIGN**
- ☐ **COMMUNICATIONS BARRIERS PROHIBITED OBTAINING THE ACKNOWLEDGEMENTS**
- ☐ **OTHER (PLEASE SPECIFY):** ______________________________________

414.962.8100 familytreedds@yahoo.com

4655 N PORT WASHINGTON RD - SUITE 125 | GLENDALE WI, 53212

familytreedds.com