PRAIRIE LAKES DENTAL

Dr. Adam L. Forster, DDS
Dr. Matthew R. Clary, DDS
Dr. Martin Jasek, DDS

Personal Information

Name: _____

I prefer to be called: _____

† Single † Married † Divorced † Widowed

† Male † Female

Birth date:_____/_____/_____ Age_____ _____

SSN#:_____-_____-_____

Street Address: _____

Apt:_____ City: _____

State:_____ Zip: _____

Home Phone:(_____)_____- _____

Cell Phone:(_____)_____- _____

Email Address: _____

Employer: _____

Occupation: _____

Work Phone:(____)_____- _____

How did you hear about us? _____

Parent's Information *(If under age 18)*

Mother † Step mother † Guardian

Name:_____ Birthdate ___/___/___

Home/Cell _____ Work _____

Employer: _____

SS# _____ DL#_____

Father † Step Father † Guardian

Name:_____ Birthdate ___/___/___

Home/Cell _____ Work _____

Employer: _____

SS# _____ DL#_____

Dental Insurance

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone: (____)_____- _____

Group#: _____

Member ID# _____

Insured's Name: _____

Relation: _____

Insured's Birth date:_____/_____/_____

Insured's SSN#:_____-_____-_____

Insured's Employer: _____

Health Insurance _____

Spouse Information

Name: _____

Employer: _____

Cell:_____Work:_____

Birth date:_____/_____/_____

Dental History

Who was your previous dentist?_____

When was your last dental visit?_____/_____/_____

When were your last dental x-rays taken?____/____/____

Are you currently sensitive or in pain? _____

Do you like your smile? _____

How many times a day do you brush? _____

How many times a week do you floss? _____

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. If my bill is placed in the hands of an attorney or collection agency for purposes of collection after default, I promise to pay all reasonable attorneys' fees and all other reason-able collection fees incurred. Furthermore, if a suit is in-stituted to enforce collection of my bill, I promise to pay all court costs associated with said legal action.

Our office policy is payment in full day of service. 5% discount is offered for cash, check or 3rd party payment. We accept Master Card and Visa. We also offer 3rd party no interest payment plans.

SIGNATURE **DATE**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Medical History

Although dental personnel primarily treat 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.

Have you been informed to take a **pre-medication** before a dental appointment? ☐ Yes ☐ No

Have you previously or currently been taking Bisphosphonates?(ex: Aledronate, Fosamax, Zometa) ☐ Yes ☐ No

Are you under a physician's care now? ☐ Yes ☐ No

If yes, please explain: _____

Physician's Name:_____Number: _____

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 on a special diet? ☐ Yes ☐ No

Do you use tobacco? How many daily?_____ For how long?_____ ☐ Yes ☐ No

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No

*If yes, please list:*_____

_____

Are you allergic to any of the following: ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Latex ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Sulfa ☐ Tetracycline ☐ Others:

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

- ☐ Arthritis
- ☐ Emphysema
- ☐ Cancer
- ☐ Asthma
- ☐ Aids/HIV Positive
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Ulcers
- ☐ Blood Transfusion
- ☐ Tumors or Growths
- ☐ Chemotherapy
- ☐ Cold Sores/Fever Blister
- ☐ Chest Pains
- ☐ Diabetes
- ☐ Congenital Heart Disorder
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Fainting/Dizziness
- ☐ Heart Attack
- ☐ Frequent Headaches
- ☐ Heart Murmur
- ☐ Heart Pace Maker
- ☐ Hemophilia
- ☐ Leukemia
- ☐ High Blood Pressure
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Psychiatric Care
- ☐ Mitral Valve Prolapse
- ☐ Pain In Jaw Joints
- ☐ Radiation Treatments
- ☐ Renal Dialysis
- ☐ Recent Weight Loss
- ☐ Rheumatic Fever
- ☐ Hepatitis
- ☐ Sinus Trouble
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Stomach/Intestinal Disease

Women Only: ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Due Date: _____/_____/_____

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.