



# WELCOME

Thomas O. Marxen D.D.S., M.S.D.

We strive for excellence in providing you with personal and professional service in a comfortable, caring environment through the most efficient means that is rewarding for both the Patient and the Dental Team.

## 1 PATIENT INFORMATION

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_  
LAST FIRST M.I. MR MRS MS DR

I prefer to be called: \_\_\_\_\_  Male  Female

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_\_

Home Address: \_\_\_\_\_  
APT/CONDO #

CITY STATE ZIP  
 Single  Married  Divorced  Widowed  Separated

Home# \_\_\_\_\_ Pager/Cell/Other #: \_\_\_\_\_

E-mail address \_\_\_\_\_

WK#: \_\_\_\_\_ Ext. \_\_\_\_\_

Employer: \_\_\_\_\_

How long there? \_\_\_\_\_ Occupation \_\_\_\_\_

Who may we Thank for referring you? \_\_\_\_\_

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

Previous Dentist: \_\_\_\_\_

Last Visit Date: \_\_\_\_\_

Person Responsible for Account: \_\_\_\_\_

WK: \_\_\_\_\_ Ext. \_\_\_\_\_ HM #: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Relationship: \_\_\_\_\_ SS #: \_\_\_\_\_

Employer: \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_

## 2 SPOUSE INFORMATION

Their Name: \_\_\_\_\_

Employer: \_\_\_\_\_

WK #: \_\_\_\_\_ Ext \_\_\_\_\_ SS #: \_\_\_\_\_

Birthdate: \_\_\_\_\_

## 3 DENTAL INSURANCE

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_

Group # (Plan, Local or Policy): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

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

Insured's Employer: \_\_\_\_\_

If child over 18 - Full time student? Yes  No

### Additional Dental Insurance

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_

Group # (Plan, Local or Policy): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

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

Insured's Employer: \_\_\_\_\_

*In the event of an emergency, is there someone who lives near you that we should contact?*

Their Name: \_\_\_\_\_ Relation: \_\_\_\_\_

WK #: \_\_\_\_\_ HM #: \_\_\_\_\_

## 4 MEDICAL HISTORY

Do you have a personal physician?  No  Yes

Physician's Name: \_\_\_\_\_

Phone #: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

CONTINUED ON BACK OF FORM

# 4

## MEDICAL HISTORY *continued*

Your current physical health is  Good  Fair  Poor

Are you currently under the care of a physician?  No  Yes

Please explain \_\_\_\_\_

Are you taking any prescription/over-the-counter drugs?  No  Yes

Please list each one \_\_\_\_\_

Do you need to be pre-medicated?  No  Yes

For Women Are you taking birth control pills?  No  Yes

Are you pregnant?  No  Yes Week # \_\_\_\_\_

Are you nursing?  No  Yes

Caution: An alternate method of birth control should be used if taking antibiotics.

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

- |  |   |
|--|---|
| <input type="checkbox"/> Heart Attack / Stroke       | <input type="checkbox"/> Psychiatric Problems                 |
| <input type="checkbox"/> Cancer / Chemotherapy       | <input type="checkbox"/> Epilepsy / Seizure / Fainting Spells |
| <input type="checkbox"/> Heart Murmur                | <input type="checkbox"/> Diabetes / Tuberculosis (TB)         |
| <input type="checkbox"/> Rheumatic Fever             | <input type="checkbox"/> Drug / Alcohol Abuse                 |
| <input type="checkbox"/> HIV+ / AIDS                 | <input type="checkbox"/> Venereal Disease                     |
| <input type="checkbox"/> Heart Surgery / Pacemaker   | <input type="checkbox"/> Hemophilia / Abnormal Bleeding       |
| <input type="checkbox"/> Mitral Valve Prolapse       | <input type="checkbox"/> Congenital Heart Defect              |
| <input type="checkbox"/> Kidney Problems             | <input type="checkbox"/> Anemia / Radiation Treatment         |
| <input type="checkbox"/> Artificial Bones / Joints   | <input type="checkbox"/> Asthma / Arthritis                   |
| <input type="checkbox"/> Artificial Valves           | <input type="checkbox"/> Difficulty Breathing                 |
| <input type="checkbox"/> Sinus Problems              | <input type="checkbox"/> Hospitalized for Any Reason          |
| <input type="checkbox"/> High Blood Pressure         | <input type="checkbox"/> Hepatitis                            |
| <input type="checkbox"/> Severe / Frequent Headaches | <input type="checkbox"/> Blood Transfusion                    |
| <input type="checkbox"/> Emphysema / Glaucoma        | <input type="checkbox"/> Low Blood Pressure                   |

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

\_\_\_\_\_

\_\_\_\_\_

### Are you allergic to any of the following drugs?

- |                               |                        |              |
|-------------------------------|------------------------|--------------|
| Y N Penicillin                | Y N Tetracycline       | Y N Percodan |
| Y N Aspirin                   | Y N Dental Anesthetics | Y N Demerol  |
| Y N Erythromycin              | Y N Codeine            | Y N Valium   |
| Y N Other (Please list) _____ |                        |              |

Do you smoke? \_\_\_\_\_ How Much \_\_\_\_\_

Do you use smokeless tobacco? \_\_\_\_\_ How often \_\_\_\_\_

# 5

## DENTAL HISTORY

Why have you come to the dentist today? \_\_\_\_\_

Are you currently in pain?  No  Yes

Have you ever had a serious / difficult problem associated with any previous dental work?  No  Yes

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ/TMD)?  No  Yes

Your current dental health is  Good  Fair  Poor

Do you like your smile?  No  Yes

Do you want a whiter smile?  No  Yes

Do you wish you could improve your smile?  No  Yes

Do your gums ever bleed?  No  Yes

How many times a week do you floss? \_\_\_\_\_

How many times a day do you brush? \_\_\_\_\_

Type of bristles?  Hard  Medium  Soft

### Consent for Treatment

I do authorize and give consent to the doctor and his staff to administer treatment, including, but not limited to, local anesthesia, analgesia and other such treatment which may be necessary for the above named patient. I also understand that the use of these agents and some procedures embodies a certain risk. I further state that the above medical and dental history was completed fully and accurately to the best of my knowledge.

A service charge of 1.5% per month (18% per annum) but in no event more than the maximum rate permissible under state law will be charged on the unpaid balance on all accounts not paid within 90 days of treatment date. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependent is mine. Unless prior special arrangements are made, accounts are to be paid on date which services are provided. I hereby authorize that the payment from any insurance company due me be paid directly to this office. In the event of default in my payment, patient or party responsible for fees agree to pay any and all cost of suit, collection and attorney's fees. I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form.

Signature - Patient or Responsible Party \_\_\_\_\_ Date \_\_\_\_\_

**Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.**

## OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Comments: \_\_\_\_\_

### MEDICAL HISTORY UPDATE

1. Date \_\_\_\_\_ Comments \_\_\_\_\_ Signature \_\_\_\_\_

2. Date \_\_\_\_\_ Comments \_\_\_\_\_ Signature \_\_\_\_\_

3. Date \_\_\_\_\_ Comments \_\_\_\_\_ Signature \_\_\_\_\_