A B C

Patient Information

Patient Name: _____
Last First Middle

Date:_____ ☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐ Child ☐ Other_____

Address: _____
Street City State Zip Code

Home Phone: _____ Birth Date_____ Social Security #: _____

Whom may we thank for referring you to our office?_____

Have you visited our web site at www.drwiele.com?_____

Responsible Party Information

Please fill out entirely. May indicate "same as above" where applicable.

Name: _____
Last First Middle

Address: _____
Street City State Zip Code

How long at this address?_____ Home phone _____Work phone_____

Mobile phone _____E-mail _____

Previous address (if less than 3 yrs.)_____
Street City State Zip Code

Social Security #: _____ Birth Date: _____ Relationship to patient _____

Employer _____ Occupation_____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation_____ No. Years Employed _____

Social Security #: _____ Birth Date: _____ Work Phone _____

Insurance Information

Dental Insured's Name: _____ Soc. Security # _____

Dental Insurance Company _____ Group #:_____ Local # _____

Dental Insurance Company's address _____

Medical Insurance Company _____ Group #:_____ Local # _____

Medical Insured's name _____ Soc. Security # _____

Medical Insurance Company's address _____

Do you have dual coverage? Yes No If yes, dental or medical?

Insured's Name: _____ Soc. Security # _____

Insurance Company: _____ Group #:_____ Local # _____

Insurance Company Address: _____

Insured's Employer _____

Emergency Information

Name of nearest relative not living with you: _____

Complete Address:_____

Phone (Home): _____ Phone (Work) _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor)_____

Updates (date and initial) _____ _____ _____ _____ _____

Medical History

Do you have or have you had: (Please circle or highlight)

Heart Failure	Artificial Joint	Allergies or Hives	Liver Disease
Heart Disease or Attack	Anemia	Diabetes	Yellow Jaundice
Angina Pectoris	Stroke	Thyroid Disease	Blood Transfusion
High Blood Pressure	Kidney Trouble	X-ray or Cobalt Treatment	Drug or Alcohol Abuse
Heart Murmur	Ulcers	Chemotherapy	Hemophilia
Rheumatic Fever	Emphysema	Arthritis	Venereal Disease
Congenital Heart Lesions	Chronic Bronchitis	Rheumatism	Cold Sores
Scarlet Fever	Cough	Cortisone	Epilepsy or Seizures
Artificial Heart Valve	Tuberculosis (TB)	Glaucoma	Fainting or Dizzy Spells
Mitral Valve Prolapse	Asthma	AIDS or HIV	Psychiatric Treatment
Heart Surgery	Latex allergy	Hepatitis A (infectious)	Bruise Easily
Heart Pacemaker	Sinus Trouble	Hepatitis B (serum)	Hepatitis C

What is your physician's name?_____ Phone _____

Are you allergic to any medications? Please list _____Yes No

Are you currently taking any medications? If so, please list _____Yes No

_____

Have you ever been hospitalized or had any operations?_____Yes No

_____

Have you had any excessive bleeding requiring special treatment? …… Yes No

Are you or do you suspect you may be pregnant? …….. Yes No

Are you nursing?……. Yes No

Are you taking oral contraceptives? (antibiotics can inactivate them) …….. Yes No

Dental History

Are you currently in pain? Where?_____Yes No

Are you nervous about dental treatment?..... Yes No
If so, please explain? _____

Are your gums sore, or do they bleed when you brush your teeth? …… Yes No

Are you ever troubled with bad breath or a bad taste in your mouth? …… Yes No

Are you one of the many who has never been given professional homecare instructions?..... Yes No

Do you smoke or use smokeless tobacco?……...… Yes No
If so, would you like tobacco cessation counseling? Yes No

Do you wear removable dentures or appliances? How many sets have you had?_____Yes No
When was the last set made?_____

Do you snore while sleeping? Yes No

Have you ever done a sleep study? How long ago? _____ Yes No

Have you ever been diagnosed with obstructive sleep apnea? If yes, when?_____ Yes No

Do you have, or have you had headaches? How often?_____Yes No

Do you know if you clench or grind your teeth? Day or Night?_____Yes No

Does your jaw ever pop or click? …….. Yes No

Do you have ringing or buzzing sounds in your ears? …….. Yes No

Has your jaw ever been locked open or closed? …… Yes No

Have you ever had orthodontic treatment? When _____ By whom_____Yes No

Do you have any missing teeth that have NOT been replaced? If yes, why?_____Yes No

Would you like your teeth to be whiter? …… Yes No

Are you dissatisfied with your smile? …… Yes No
If so, why? _____

Please write below any additional concerns or information we have not asked.

Check what type of dental service you are seeking:

- ☐ Emergency treatment – elimination of pain
- ☐ Crisis management of an injury sustained in accident
- ☐ Cosmetic treatment of a limited nature
- ☐ Bleeding or inflamed gums
- ☐ Silver-Mercury filling replacement
- ☐ Total replacement of metal restorations
- ☐ Removal of a root canal treated tooth
- ☐ TMJ and bite evaluation
- ☐ Other – please explain: _____

Check the payment option that suits you best. If you have dental insurance, how will you pay the portion insurance does not cover?

- ☐ Cash or check when services are rendered
- ☐ Credit card: Visa, MasterCard, or Discover when services are rendered
- ☐ 5% prepay discount for a comprehensive treatment plan
- ☐ Dental financing through outside lending institution, arranged here in the office
- ☐ Other, please explain: _____

I authorize release of any information relating to any dental claims. I authorize payment of the dental or medical benefits payable directly to Gary B. Wiele, D.D.S. I understand that I may be charged an 18% late fee on past due bills and $50 for any returned checks I may write. I understand that if appointments are broken or changed without a 24 hour notice, appropriate fees will be charged. I understand that I am financially responsible for any and all charges not covered by my insurance. I agree to pay my account regardless of such coverage. If additional steps are required to collect this account, I agree to pay all costs of collection including court costs and reasonable attorney fees. I authorize the use of any information or photos for the purpose of teaching or publishing articles. I understand for the purpose of account servicing or to collect amounts owed, I may be contacted at any and all telephone numbers associated with this account including wireless telephone numbers. Methods of contact may include pre-recorded voice messages, use of an automatic dialing device, text messaging and emails. I have read this disclosure and agree to the above terms.

I consent treatment for my minor child.

Signature_____ Signature_____

Date_____