

Instructions and Comments for Forms View / Download

Dear Prospective Patient:

Thank you for taking the time to view and/or download our introductory forms. We appreciate that you are considering us for your dental care. Please note that if you are currently experiencing a dental problem, especially one that involves pain, discomfort, or an undesirable change in your appearance, you should contact me as soon as possible so that I can see you on an emergency basis. You can do so by calling our office at 414-962-1800 (toll free: 877-962-1800). If I am not at the office, the outgoing message on the answering machine will inform you as to how to get a hold of me.

Regarding these forms, you should be able to print them in their original format, whether you have downloaded them in the PDF (Adobe) or Microsoft Word formats. My experience is that the PDF format will give you the most exact replica of the original forms. The medical history form does utilize some minimal color, so, if possible, please print this document on a **color** printer.

Since this feature of our website is relatively new (December, 2000), we are most interested in your feedback. I am especially interested in any problems that Macintosh users may be having. If you have any questions or problems downloading these forms (i.e. they don't look right, the formatting looks weird, or the load time is way too long), please email me at drhart@drhart.com.

Again, thanks for your interest in our website and our office. Please contact Dana (our office manager), or me if you have any problems or concerns.

Sincerely,

Tim Hart

Your Name: _____
Last First Init.

Date of Birth: ___/___/___

Please circle the appropriate answer. If you don't know the correct answer, please write "Don't Know" on the line after the question. If you answer yes, and there is an arrow to the right ("YES>"), please add any appropriate explanation in the comment box to the right. Thank you for your help.

1.	Physician's name: City and Phone # (if known):	NO	YES	COMMENTS:
2.	Are you currently under a physicians care? For what condition?	NO	YES	
3.	When was your last complete physical examination?	NO	YES	
4.	Are you taking any medication or substances? (If yes, please list medications in the "Comments" box to the right)	NO	YES	
5.	Are you allergic to any medications or substances? (if yes, please explain at right)	NO	>YES>	
6.	Do you have any problems with penicillin, antibiotics, anesthetics, or other medications?	NO	>YES>	
7.	Are you sensitive to any metals or latex?	NO	>YES>	
8.	Are you pregnant or suspect that you may be?	NO	YES	
9.	Do you use any birth control medications?	NO	YES	
10.	Have you ever been treated for or been told you might have heart disease?	NO	>YES>	
11.	Do you have a pacemaker or an artificial heart valve implant?	NO	YES	
12.	Have you ever had rheumatic fever?	NO	YES	
13.	Are you aware of any heart murmurs?	NO	YES	
14.	Do you have high or low blood pressure?	NO	YES	
15.	Have you ever had a serious illness or major surgery? If so, please explain here or in box at right:	NO	>YES>	
16.	Have you ever had radiation treatment or chemo therapy?	NO	>YES>	
17.	Do you have inflammatory diseases, such as arthritis or rheumatism?	NO	YES	
18.	Do you have any artificial joints or prosthesis?	NO	YES	
19.	Do you have any blood disorders, such as anemia, leukemia, etc.?	NO	>YES>	
20.	Have you ever bled excessively after being cut or injured?	NO	YES	
21.	Do you have any stomach problems?	NO	>YES>	
22.	Do you have any kidney problems?	NO	>YES>	
23.	Do you have any liver problems?	NO	>YES>	
24.	Are you diabetic?	NO	YES	
25.	Do you have asthma?	NO	YES	
26.	Do you have epilepsy or seizure disorders?	NO	YES	
27.	Do you or have you had a venereal disease?	NO	YES	
28.	Have you ever tested positive to HIV infection or AIDS?	NO	YES	
29.	Have you ever tested positive for hepatitis (other than hepatitis A)?	NO	YES	
30.	Do you or have you had T.B.?	NO	YES	
31.	Do you smoke, chew, use snuff, or any other form of tobacco?	NO	YES	
32.	Do you consume alcoholic beverages?	NO	YES	
33.	Do you habitually use controlled substances, especially cocaine?	NO	YES	
34.	Have you had psychiatric treatment?	NO	YES	
35.	Have you taken the prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dextenfluramine (redux), or other weight loss products?	NO	YES	
36.	Would you like to speak to Dr. Hart in private about any problem?	NO	YES	
37.	Do you have any disease, condition, or problem not listed? Is so, please explain here or in box at right:	NO	>YES>	
38.	Is there anything else we should know about your health that we have not covered in this form? If so, please explain here or in box at right:	NO	>YES>	

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE & ACCURATE: _____
 DATE: _____

MEDICAL HISTORY

Your Name: _____
Last First Init.

Date of Birth: ___/___/___

Guardian's Name: _____

Dental Insurance: 1st Coverage:

Employee Name	
Employee Date of Birth	
Employer	
Number of Years	
Name of Insurance Co.	
Address	
Telephone	
Program or Policy #	
Social Security #	

How do you wish to be addressed?	
Residence: Street City State and Zip Code	
Business Address: Street City State and Zip Code	
Telephone Numbers: Residence Business Cellular / Mobile Fax Email address	
Patient / Parent Employed by	
Present Position, and How long held?	
After any insurance, who is responsible for this account?	
What is the purpose of your seeking our care?	
Other family member in our practice?	
Whom may we thank for this referral?	
Patient / Parent Social Security #	
Spouse / Parent Social Security #	
Someone to notify in case of emergency, not living with you?	

Dental Insurance: 2nd Coverage:

Employee Name	
Employee Date of Birth	
Employer	
Number of Years	
Name of Insurance Co.	
Address	
Telephone	
Program or Policy #	
Social Security #	

RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
 I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
 I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.
 I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.
 I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.
 I attest to the accuracy of the information on this page.

Patient's or Guardian's Signature _____ Date _____