funke
family dentistry

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PATIENT INFORMATION

(confidential)

Name: _____ Today's Date: _____
LAST FIRST MIDDLE

Maiden Name (women): _____ SS #: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____ Work Phone: ( ) _____

Email: _____ Sex: ☐ Male ☐ Female DOB: _____ Age: _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Driver's License #: _____

Current Patient Employer: _____ Occupation: _____

Employer Address: _____ Phone: ( ) _____

In case of emergency, who should be notified? _____ Phone: ( ) _____

Spouse's Name (if applicable) _____ Phone: ( ) _____

Whom may we thank for referring you? _____

PRIMARY DENTAL INSURANCE

Person responsible for account: _____

Relation to patient: _____

Subscriber's date of birth: _____

Subscriber's SS #: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: ( ) _____

Person responsible employed by: _____

Business Address: _____

Insurance Co: _____ Group #: _____

Subscriber #: _____ Contact #: _____

Insurance Mailing Address: _____

City: _____ State: _____ Zip: _____

Other dependents on plan: _____

Yearly Dental Maximum: _____

SECONDARY DENTAL INSURANCE

Person responsible for account: _____

Relation to patient: _____

Subscriber's date of birth: _____

Subscriber's SS #: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: ( ) _____

Person responsible employed by: _____

Business Address: _____

Insurance Co: _____ Group #: _____

Subscriber #: _____ Contact #: _____

Insurance Mailing Address: _____

City: _____ State: _____ Zip: _____

Other dependents on plan: _____

Yearly Dental Maximum: _____

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MEDICAL HISTORY

Physician's Name: _____ Date of last visit: _____
Have you ever been hospitalized? ☐Yes ☐No If yes, please explain: _____
_____

Have you ever taken bisphosphonate drugs? ☐Yes ☐No Have you ever taken Phen-Fen or Redux? ☐Yes ☐No
Women: Pregnant or trying to get pregnant? ☐Yes ☐No Using oral contraceptives? ☐Yes ☐No Nursing? ☐Yes ☐No

Please check anything listed below that applies to you:

☐ Abnormal Bleeding	☐ Cigar/Pipe Smoking	☐ Hepatitis (Type: _____)	☐ Scarlet Fever
☐ Allergies - Seasonal	☐ Cigarette Smoking	☐ Herpes	☐ Seizures / Epilepsy
☐ Anemia	☐ Congenital Heart Defect	☐ High Blood Pressure	☐ Shortness of Breath
☐ Angina Pectoris	☐ Diabetes (Type: _____)	☐ HIV/AIDS	☐ Sinus Problems
☐ Arthritis/Gout	☐ Emphysema	☐ Jaundice	☐ Stroke
☐ Artificial Heart Valves	☐ Fainting/Dizzy Spells	☐ Liver/Kidney Disease	☐ Swollen Glands
☐ Artificial Joints	☐ Gastric Reflux	☐ Low Blood Pressure	☐ Thyroid Disease
☐ Back Problems	☐ Glaucoma	☐ Pacemaker	☐ Tobacco Chewing
☐ Bacterial Endocarditis	☐ Headaches	☐ Radiation/Chemotherapy	☐ Tuberculosis
☐ Blood Thinners	☐ Heart Disease/Attack	☐ Respiratory Disease	☐ Tumor/Growths
☐ Cancer (Type: _____)	☐ Heart Surgery	☐ Rheumatic Fever	☐ Ulcers
☐ Chest Pains	☐ Hemophilia	☐ Sexually Transmitted Disease	

Please add and explain any serious medical problems not listed above: _____
_____

Are you allergic to any of the following? (check all that apply)
☐Penicillin ☐Codeine ☐Vicoden ☐Iodine ☐Latex ☐Local Anesthetic ☐Sleeping Pills ☐Other: _____

Please provide a list of any and all prescription and non-prescription medications you are currently taking: _____
_____
_____
_____

DENTAL HISTORY

Are you happy with your previous dental experience? ☐Yes ☐No If no, please explain: _____
Reason for today's visit: _____ Date of last dental care: _____
Former Dentist: _____ Date of last dental x-rays: _____

Have you ever chronically experienced any of the following? (check all that apply)

☐ Bad Breath	☐ Dry Mouth	☐ Hot/Cold Sensitivity	☐ Orthodontic Work
☐ Bleeding Gums	☐ Grinding/Clenching	☐ Jaw Pain	☐ Sores in Mouth
☐ Chewing Pain	☐ Gum Disease	☐ Loose/Broken Teeth	☐ Sweet Sensitivity

How often do you brush? _____ How often do you floss? _____
Are you happy with how your teeth look? ☐Yes ☐No Are you interested in whitening your teeth? ☐Yes ☐No
Have you had or are interested in BOTOX©? ☐Yes ☐No Would you like Nitrous (laughing gas)? ☐Yes ☐No
Would you like medication to calm your nerves before treatment? ☐Yes ☐No

To the best of my knowledge, the questions on this form have been accurately answered. I understand providing incorrect information may be dangerous to my (or patient's) health. It is my responsibility to inform **Funke Family Dentistry** of any changes in medical status.

Signature of Patient, Parent or Guardian: _____ Date: _____

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