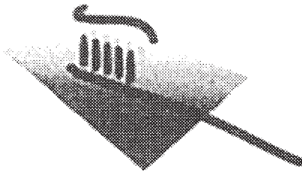

MONONA DENTAL, S.C.
RICHARD H. TETEAK, D.D.S.

WELCOME TO OUR OFFICE

DATE ______________________ NAME ______________________________ D.O.B. __________

WHAT NAME WOULD YOU PREFER WE CALL YOU? ______________________________ Marital Status

HOME ADDRESS ____ S__ M__ D__

CITY AND ZIP ______________________________ E-MAIL ______________________________

HOME PHONE ______________________ SOCIAL SECURITY ______________________________

EMPLOYER ______________________ WORK PHONE ______________ EXT. __________

MAY WE CALL YOU AT WORK? ___ YES ___ NO

WHO MAY WE THANK FOR REFERRING YOU? ______________________________

MEDICAL HISTORY

Physician's Name ______________________________ Date of Last Visit ______________

Place a mark on "Yes" or "No" for the following conditions

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
AIDS/ARC/HIV+	☐ Yes	☐ No	Exposure to Hepatitis	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Exposure to Tuberculosis	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	*Heart Murmur	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No
*Artificial Heart Valves	☐ Yes	☐ No	*Heart Problems	☐ Yes	☐ No	*Rheumatic Fever	☐ Yes	☐ No
*Artificial Joints	☐ Yes	☐ No	Hepatitis Type_____	☐ Yes	☐ No	Sexually Transmitted Disease	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Seizure Disorder	☐ Yes	☐ No
Cancer/Tumors	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
*Congenital Heart Lesions	☐ Yes	☐ No	Latex Allergy	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Excessive Bleeding	☐ Yes	☐ No	*Mitral Valve Prolapse	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No

*these conditions may require medication prior to treatment

Other disease or conditions you may have:	Medications you are taking:	Allergies you have:
______________	______________	______________
______________	______________	______________
______________	______________	______________

Are you (circle) Pregnant Nursing Menopausal

DENTAL HISTORY

Date of last dental visit? __________ Treatment Received __________

Are you satisfied with past dental care? ☐ Yes ☐ No

Please explain: ______________________

Do you like the appearance of your smile? ☐ Yes ☐ No

Please explain: ______________________

Do you have fluoride in your home drinking water? ☐ Yes ☐ No

Are you having any discomfort now? ☐ Yes ☐ No

If so, please explain: ______________________

Have you lost any teeth? ☐ Yes ☐ No

For what reason: ______________________

Do you wear a removable partial or complete denture? ☐ Yes ☐ No

What makes you nervous about dental visits? ______________________

____

Are you interested in using nitrous oxide during treatment? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No How much? ______________

Do you chew tobacco? ☐ Yes ☐ No How often? ______________

Are your teeth sensitive to: (circle) Hot Brushing Cold Chewing

Do your gums bleed when you: (circle) Brush Floss Use Toothpicks

Are your gums: (circle) Red Swollen Tender

Do you have bad breath or bad taste? ☐ Yes ☐ No

Do you clench or grind your teeth? ☐ Yes ☐ No

Do you wake up with jaw pain or headaches? ☐ Yes ☐ No

Do you experience: (circle) Canker Sores Cold Sores

Would you like your teeth whiter? ☐ Yes ☐ No

Do you have well water? ☐ Yes ☐ No

List what you do to keep your teeth and gums healthy ______________

____

(over)

INSURANCE INFORMATION

DENTAL INSURANCE PLAN ONE

EMPLOYER NAME:
INSURANCE CO. NAME:
ADDRESS:
CITY:
STATE AND ZIP:
GROUP ID:

EMPLOYEE INFORMATION

RELATION TO INSURED:
INSURED'S NAME:
ADDRESS:
CITY:
STATE AND ZIP:
PHONE:
SUBSCRIBER ID:
INSURED'S BIRTH DATE:

DENTAL INSURANCE PLAN TWO

EMPLOYER NAME:
INSURANCE CO. NAME:
ADDRESS:
CITY:
STATE AND ZIP:
GROUP ID:

EMPLOYEE INFORMATION

RELATION TO INSURED:
INSURED'S NAME:
ADDRESS:
CITY:
STATE AND ZIP:
PHONE:
SUBSCRIBER ID:
INSURED'S BIRTH DATE:

OFFICE POLICY

Payment is expected the day of the appointment including co-insurance and deductibles. We offer a 5% discount of payments made in full on cash accounts. We honor MasterCard, Visa, Discover, and Care Credit. We reserve the right to charge for appointments cancelled or broken without 24 hour advance notice.

In most cases, insurance does not cover the full cost of services. It is designed to reduce your cost, but not to eliminate it completely. Our staff will help you receive the maximum benefit under your policy. However, you are fully responsible for all fees charged by this office regardless of your insurance coverage.

I have read and hereby agree to the policy of this office. The medical/dental history is accurate to the best of my knowledge.

Patient Signature ______________________ Dentist Signature ______________________

UPDATES

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions: ______________________

Are you taking any new medications? ☐ Yes ☐ No

If so what? ______________________

Patient Signature ______________________ Date ____________

Dentist Signature ______________________ Date ____________

UPDATES

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions: ______________________

Are you taking any new medications? ☐ Yes ☐ No

If so what? ______________________

Patient Signature ______________________ Date ____________

Dentist Signature ______________________ Date ____________