

LAST NAME	FIRST NAME	MIDDLE	BIRTH DATE Mo.-Day-Yr.	HEIGHT	WEIGHT	MARITAL STATUS
NAME YOU WOULD LIKE TO BE CALLED						PATIENT SOCIAL SECURITY #
RESIDENCE ADDRESS	CITY	STATE	ZIP	RESIDENCE TELEPHONE	CELL TELEPHONE	
EMPLOYER	ADDRESS		CITY	STATE	ZIP	BUSINESS TELEPHONE
NAME OF HUSBAND, WIFE OR PARENT		D.O.B.	DENTAL INSURANCE CARRIER		INSURED SOCIAL SECURITY #	
REFERRED BY		NAME OF PHYSICIAN			TELEPHONE	

**GENERAL**

**Circle One**

- 1) Has there been any change in your general health during the last year? Yes No DK
- 2) Have you been examined by your physician within the last year? Yes No DK
- 3) Are you receiving any treatment by any doctor now? Yes No DK
- 4) Are you taking any medicines now? Yes No DK
- 5) Have you taken or are you currently taking any medication for bone cancer or osteoporosis? Yes No DK
- 6) Have you ever had an operation? Yes No DK
- 7) Have you ever had a serious illness? Yes No DK
- 8) Have you ever been hospitalized? Yes No DK
- 9) Has a dentist or physician ever told you that you had a tumor or a cancer? Yes No DK
- 10) Have you ever had x-ray treatments? Yes No DK
- 11) Have you had rheumatic fever, rheumatic heart disease, growing pains, or twitching of the limbs? Yes No DK
- 12) Have you had a stroke (apoplexy, CVA)? Yes No DK
- 13) Have you ever had excessive bleeding following extraction of teeth or from a cut? Yes No DK
- 14) Are you allergic or sensitive to any particular medicine (Aspirin - Penicillin)? Yes No DK
- 15) Have you ever had an anesthetic? Local? Yes No General? Yes No Yes No DK
- 16) Have you ever been told not to take novocaine? Yes No DK
- 17) Do you suffer badly from frequent severe headaches? Yes No DK
- 18) Do you have spells of dizziness? Yes No DK
- 19) Have you fainted more than twice in your life? Yes No DK
- 20) Have you ever had severe pains of the face or head? Yes No DK
- 21) Have you ever been treated for eye trouble other than corrective glasses? Yes No DK
- 22) Have you ever been treated for ear trouble? Yes No DK
- 23) Do you have hay fever? Yes No DK
- 24) Do you have sinus trouble? Yes No DK
- 25) Have you at times had bad nose bleeds? Yes No DK
- 26) Do you have frequent sore throats? Yes No DK
- 27) Are you or have you ever been addicted to any medications, substances or alcohol? Yes No DK
- 28) Have you ever been diagnosed HIV positive? Yes No DK

**CARDIOVASCULAR**

- 29) Has a physician ever said you had heart trouble? Yes No DK
- 30) Have you ever had rheumatic heart disease? or Saint Vitus' dance? Yes No DK
- 31) Have you ever had a heart attack? Yes No DK
- 32) Has a physician ever said your blood pressure was too high or too low? Yes No DK
- 33) Do you get out of breath easily? Yes No DK
- 34) Are your ankles often badly swollen? Yes No DK
- 35) Do you bruise easily? Yes No DK
- 36) Do you have a heart murmur? Yes No DK

**GASTRO-INTESTINAL**

- 37) Do you suffer from stomach trouble? Yes No DK
- 38) Have you ever had liver trouble? Yes No DK
- 39) Do you have frequent diarrhea? Yes No DK
- 40) Has a physician ever told you that you had ulcers? Yes No DK
- 41) Are there any foods you cannot eat? Yes No DK
- 42) Have you gained or lost weight recently? Yes No DK
- 43) Have you ever been jaundiced? Yes No DK
- 44) Have you ever had hepatitis? Yes No DK

**RESPIRATORY**

**Circle One \***

- 45) Have you ever coughed up blood? Yes No DK
- 46) Do you have asthma? Yes No DK
- 47) Have you ever had tuberculosis? Yes No DK
- 48) Have you ever lived with anyone who had TB? Yes No DK

**GENITO-URINARY**

- 49) Are you thirsty much of the time? Yes No DK
- 50) Did a physician ever say that you had kidney or bladder trouble? Yes No DK
- 51) Do you have to get up every night to urinate? Yes No DK
- 52) Have you ever had syphilis? Yes No DK

**FEMALE**

- 53) Are you currently pregnant? Yes No DK  
 Number of pregnancies.....  
 Number of children.....
- 54) Is your menstrual cycle irregular? Yes No DK
- 55) Have you reached the menopause? (Change of life) Yes No DK

**ENDOCRINE SYSTEM**

- 56) Have you ever had diabetes? Yes No DK
- 57) Has a member of your family had diabetes? Yes No DK
- 58) Have you ever taken thyroid tablets? Yes No DK
- 59) Do you get tired easily? Yes No DK

**NERVOUS SYSTEM**

- 60) Have you ever had a nervous breakdown? Yes No DK
- 61) Has a physician ever told you that you had epilepsy? Yes No DK
- 62) Do you consider yourself a nervous person? Yes No DK

**SKIN**

- 63) Have you ever been treated for a skin disease? Yes No DK
- 64) Do cuts on your skin usually stay open a long time? Yes No DK
- 65) Have you ever had hives or skin rash? Yes No DK

**BONES AND JOINTS**

- 66) Are your joints often painfully swollen? Yes No DK
- 67) Have you ever had more than one fracture? Yes No DK
- 68) Have you ever had more than one dislocation? Yes No DK
- 69) Do you have arthritis or rheumatism? Yes No DK
- 70) Do you have any artificial prosthetic joints? Yes No DK

**DENTAL**

- 71) Do your gums bleed when you brush your teeth? Yes No DK
- 72) Have you ever had gum treatments? Yes No DK
- 73) Have you ever had an acute sore mouth? Yes No DK
- 74) Do your teeth ever feel sore when you bite on them? Yes No DK
- 75) Do any teeth feel high or long when you bite on them? Yes No DK
- 76) Do your jaws feel tired at the end of the day? Yes No DK
- 77) Do your jaws feel tired when you awaken in the morning? Yes No DK
- 78) Do you think your teeth are moving or drifting? Yes No DK
- 79) Do you grind or clench your teeth when you are nervous or while sleeping? Yes No DK
- 80) Do your jaws crackle or pop when you yawn or open your mouth? Yes No DK
- 81) Do you feel that an attempt to save your teeth is a waste of time? Yes No DK

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Chief Complaint:**

\_\_\_\_\_

\_\_\_\_\_

**Medical Summary:**     **NON CONTRIBUTORY**     **SIGNIFICANT**

\_\_\_\_\_

\_\_\_\_\_

\* DK = Don't Know

Patient's Name

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES  
AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement but, in refusing we  
will not be able to process your insurance claims.

Date: \_\_\_\_\_

The undersigned acknowledges ~~I have received a copy or declined a copy~~ (circle one) of the currently effective Notice of Privacy Practices for Wessel Periodontics. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS IN THE FUTURE.**

\_\_\_\_\_  
Please print your name  
name

\_\_\_\_\_  
Please sign your

\_\_\_\_\_  
Legal Representative  
Authority (ex: parent/POA)

\_\_\_\_\_  
Description of

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR DENTAL INFORMATION:  
(This includes step parents, grandparents and any care givers who can have access to your dental information)

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

Relationship: \_\_\_\_\_

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

Relationship: \_\_\_\_\_

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY DENTAL APPOINTMENTS,  
TREATMENT & BILLING INFORMATION VIA:

{ } Cell Phone Confirmation: \_\_\_\_\_

{ } Home Phone Confirmation: \_\_\_\_\_

{ } Work Phone Confirmation: \_\_\_\_\_

U. S. Mail / Postcard (required for treatment)

{ } Email (treatment/billing only) \_\_\_\_\_

{ } Fax (treatment/billing only) \_\_\_\_\_

All the Above