Douglas Retzlaff, DMD, PC
Family & Cosmetic Dentist

Welcome

Please complete the form below. The more knowledge we have of your health the better we can assist you.

1 Patient Information

Today's Date: _____ ☐ MR ☐ MRS ☐ MS ☐ DR

Name: _____
LAST FIRST MI

Preferred Name: _____ ☐ MALE ☐ FEMALE
The name you would like us to call you by

Birthdate: __/__/__ Age: _____ SS#: _____

Email Address: _____

Home Address: _____
APT/CONDO #

_____
CITY STATE ZIP

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home #: (____) _____ Pager/Cell #: (____) _____

Work #: (____) _____ Ext: ____ DL #: _____

Employer: _____

Employer's Address: _____

Occupation: _____ Years at this Job? _____

Preferred contact method: _____ Preferred time: _____
PHONE / EMAIL

Whom may we Thank for referring you? _____

Emergency Contact Name: _____ Relation: _____

Home #: (____) _____ Work #: (____) _____

2 Spouse Information

Spouse Name: _____

Employer: _____

Work #: (____) _____ Ext: ____ DL #: _____

Birthdate: __/__/__ Age: _____ SS#: _____

3 Responsible Party

Person Responsible for Account: _____

Work #: (____) _____ Ext: ____ DL #: _____

Billing Address: _____

Relation: _____ SS#: _____

Employer: _____

4 Insurance Information

Primary Insurance

Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone #: _____

Group #: _____ Policy #: _____

Subscriber's Name: _____ Relation: _____

Subscriber's Birthdate: _____

Subscriber's Employer: _____

Secondary Insurance

Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone #: _____

Group #: _____ Policy #: _____

Subscriber's Name: _____ Relation: _____

Subscriber's Birthdate: _____

Subscriber's Employer: _____

5 Medical History

Are you currently under the care of a physician: ☐ Yes ☐ No

If yes, please explain: _____

Physician's Name: _____

Phone #: (____) _____ Last Visit Date: __/__/__

Current Physical Health: ☐ Good ☐ Fair ☐ Poor

Are you currently taking any medication: ☐ Yes ☐ No

If yes, please list: _____

_____

_____

_____

CONTINUED ON BACK

6 Medical History *continued*

Have you ever taken a bisphosphonate (Fosomax or other)? ☐ Yes ☐ No

Have you ever taken Phen-fen? ☐ Yes ☐ No

Do you have or have you had any of the following?

Yes	No		Yes	No	
☐	☐	Abnormal Bleeding / Hemophilia	☐	☐	Heart Attack / Disease
☐	☐	Alcohol / Drug Abuse	☐	☐	Heart Murmur
☐	☐	Allergies or Hives	☐	☐	Heart Surgery
☐	☐	Anemia	☐	☐	Hepatitis / Liver Disease
☐	☐	Arthritis / Rheumatism	☐	☐	High / Low Blood Pressure
☐	☐	Artificial Bones / Joints / Valves	☐	☐	HIV / AIDS
☐	☐	Asthma	☐	☐	Inner Ear Disorders / Surgery
☐	☐	Blood Thinning Treatment	☐	☐	Kidney Trouble
☐	☐	Blood Transfusion	☐	☐	Liver Disease
☐	☐	Breathing Difficulties	☐	☐	Osteoporosis
☐	☐	Bruise Easily	☐	☐	Pacemaker
☐	☐	Cancer / Chemotherapy	☐	☐	Psychiatric Treatment
☐	☐	Cold Sores / Herpes	☐	☐	Rheumatic / Scarlet Fever
☐	☐	Colitis	☐	☐	Shingles
☐	☐	Congentital Heart Disease	☐	☐	Sickle Cell Disease
☐	☐	Diabetes	☐	☐	Sinus Problems
☐	☐	Emphysema	☐	☐	Stroke
☐	☐	Epilepsy or Seizures	☐	☐	Surgical Prosthesis
☐	☐	Fainting or Dizzy Spells	☐	☐	Thyroid Problems
☐	☐	Frequent Headaches	☐	☐	Tuberculosis (TB)
☐	☐	Glaucoma	☐	☐	Ulcers / Stomach Problems
☐	☐	Hay Fever	☐	☐	Venereal Disease

Other : _____

Have you had an allergic or adverse reaction to any of the following?

☐ Codeine ☐ Local Anesthetics ☐ Other: _____
☐ Epinephrine ☐ Penicillin _____
☐ Latex ☐ Sulfa Drugs

Have you ever been hospitalized? ☐ Yes ☐ No

Reason: _____

For Women Only

Are you pregnant? ☐ Yes ☐ No Due Date: _____

Are you nursing? ☐ Yes ☐ No

Do you use birth control? ☐ Yes ☐ No

7 Dental History

What brings you to our office today?

_____

_____

Date of last dental visit: ___/___/_____

Date of last full mouth x-rays: ___/___/_____

Former Dentist: _____ Phone: (___) _____

Have you ever been asked to take antibiotics or other medication before a dental appointment? ☐ Yes ☐ No

I floss ____ times per week and brush ____ times per day.

Do your gums ever bleed? ☐ Yes ☐ No

Do you use any tobacco products? ☐ Yes ☐ No

Do you like your smile? ☐ Yes ☐ No

Do you have clicking or popping in your jaw? ☐ Yes ☐ No

Previous problems with dental work? ☐ Yes ☐ No

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I acknowledge that the information I have provided is correct to the best of my knowledge and that this information will be held in the strictest confidence. I hereby authorize this Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care.

I understand that I am responsible for the payment of any dental services or treatments that my insurance does not cover. I also understand that payment may be required at time of treatment unless prior arrangements have been approved.

X _____

Patient Signature or Responsible Party Date

FOR OFFICE USE ONLY FOR OFFICE USE ONLY FOR OFFICE USE ONLY

I have reviewed the information contained in this form with the patient. Initials: _____ Date: _____

Doctor's Findings: _____

MEDICAL UPDATES

Date	Comments	Patient's Signature	Dr. Initials