Gentle Smiles Dentistry
Dr. William Wong and Dr. Joon Jae Park

Welcome!

Please fill out and email this form to:
gentlesmiles@drwongandassociates.com
Questions? Call 414-545-6747

Patient Information

Date___________________

Patient____

Address____

City____

State___________________________ Zip______________________

Email____

Sex M F Age______ Birthdate ___________________________

Married Widowed Single Minor
Separated Divorced Partnered for ____ years

Occupation____

Patient Employer/School_____________________________________

Employer/School address ____________________________________

____

Spouse name____

Birthdate _________ Spouse Occupation_______________________

Spouse employer____

Who may we thank for referring you?_______________________

____

Dental Insurance

Primary Dental Insurance Information

Subscriber's Name ____

Birthdate ___________ Relationship to Patient__________________

Insurance Co.____

Insurance Co. Phone Number__________________________________

Group #____________________ Member/ID#____________________

Secondary Dental Insurance Information

Subscriber's Name ____

Birthdate ___________ Relationship to Patient__________________

Insurance Co.____

Insurance Co. Phone Number__________________________________

Group #____________________ Member/ID#____________________

Assignment and Release *(to be signed in office on day of visit)*
I certify that I, and/or my dependent(s) have insurance coverage with
____ and assign directly to
Name(s) of Insurance Company(ies)

Dr.__________________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable, or related services.

____
Signature or Patient, Parent, Guardian or Personal Representative

____
Please print name of Patient, Parent, Guardian or Personal Representative

____
Date Relationship to Patient

Phone Numbers

Home (_____) ______________________ Cell (_____) ______________________ Work (_____) ______________________

Spouse's Cell (_____) ______________________

How would you like to be contacted to CONFIRM your appointments? RANK ORDER OF PREFERENCE: Text Email Call Cell Call Home Phone

In case of emergency, contact:

Name_____________________________ Relationship___________________________ Phone (_____) ______________________

Dental History

Reason for today's visit____________________

____

Former dentist_____________________________

City/State_________________________________

Date of last dental visit___________________

Date of last dental x-rays_________________

Check "yes" or "no" to indicate if you have had any of the following:

Bad breath	Yes	No
Bleeding gums	Yes	No
Blisters on lips or mouth	Yes	No
Burning sensation on tongue	Yes	No
Chew on one side of mouth	Yes	No
Cigarette, pipe, or cigar smoking	Yes	No
Clicking or popping jaw	Yes	No
Dry mouth	Yes	No
Fingernail biting	Yes	No
Food collection between teeth	Yes	No
Foreign objects	Yes	No
Grinding teeth	Yes	No
Gums swollen or tender	Yes	No
Jaw pain or tiredness	Yes	No
Lip or cheek biting	Yes	No
Loose teeth or broken fillings	Yes	No
Mouth breathing	Yes	No
Mouth pain, brushing	Yes	No
Orthodontic treatment	Yes	No
Pain around ear	Yes	No
Periodontal treatment	Yes	No
Sensitivity to cold	Yes	No
Sensitivity to heat	Yes	No
Sensitivity to sweets	Yes	No
Sensitivity when biting	Yes	No
Sores or growths in your mouth	Yes	No

How often do you floss?____________________

How often do you brush?____________________

Health History

Physician's Name____ Date of last visit__________ Physician's Phone #_____________________

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. Yes No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexphenfluramine). Yes No

Check "yes" or "no" to indicate if you have had any of the following:

Condition			Condition			Condition		
AIDS/HIV	Yes	No	Epilepsy	Yes	No	Respiratory Disease	Yes	No
Anemia	Yes	No	Fainting or dizziness	Yes	No	Rheumatic Fever	Yes	No
Arthritis, Rheumatism	Yes	No	Glaucoma	Yes	No	Scarlet Fever	Yes	No
Artificial Heart Valves	Yes	No	Headaches	Yes	No	Shortness of Breath	Yes	No
Artificial Joints	Yes	No	Heart Murmur	Yes	No	Sinus Trouble	Yes	No
Asthma	Yes	No	Hepatitis Type ____	Yes	No	Skin Rash	Yes	No
Back Problems	Yes	No	Herpes (cold sores)	Yes	No	Special Diet	Yes	No
Bleeding abnormally, with extractions or surgery	Yes	No	High Blood Pressure	Yes	No	Stroke	Yes	No
Blood Disease	Yes	No	Jaundice	Yes	No	Swollen Feet or Ankles	Yes	No
Cancer	Yes	No	Jaw Pain	Yes	No	Swollen Neck Glands	Yes	No
Chemical Dependency	Yes	No	Kidney Disease	Yes	No	Thyroid Problems	Yes	No
Chemotherapy	Yes	No	Liver Disease	Yes	No	Tonsillitis	Yes	No
Circulatory Problems	Yes	No	Low Blood Pressure	Yes	No	Tuberculosis	Yes	No
Congenital Heart Lesions	Yes	No	Mitral Valve Prolapse	Yes	No	Tumor or growth on head or neck	Yes	No
Cortisone Treatments	Yes	No	Nervous Problems	Yes	No	Ulcer	Yes	No
Cough, persistent or bloody	Yes	No	Pacemaker	Yes	No	Weight Loss, unexplained	Yes	No
Diabetes	Yes	No	Psychiatric Care	Yes	No			
Emphysema	Yes	No	Radiation Treatment	Yes	No			
Do you wear contact lenses?	Yes	No						

Women:
Are you pregnant? Yes No If yes: Due date__________ Are you nursing? Yes No Taking birth control pills? Yes No

Medications

List any medications that you are currently taking. If multiple medications please **attach** a printed list.

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____

____

____

____

Allergies

Aspirin

Barbiturates (Sleeping pills)

Codeine

Iodine

Latex

Local Anesthetic

Penicillin

Sulfa

Other______________________

____

____

Patient Signature *(To be signed in office on day of visit)*

Patient's signature____ Date__________________