FULMER DENTISTRY

Patient Information Form

Please fill out the below form before your visit. All information complies with HIPPA standards. You are not required to give your social security number. If you have any questions, please call us 262.657.5408.

Patient Information

Date:_____ Phone Number:_____ Alternate Phone Number:_____

Last Name:_____ First Name:_____ MI:____ SS/HIC/Patient ID #:_____

Mailing Address:_____ Email Address:_____

City:_____ State:_____ Zip Code:_____ Age: _____ Birthdate: _____

Sex: ☐ M ☐ F ☐ Married ☐ Separated ☐ Widowed ☐ Single ☐ Minor ☐ Divorced ☐ Partnered

Patient Employer/School:_____ Occupation:_____

Employer/School Address:_____ Employer/School Phone:_____

Whom may we thank for referring you?:_____

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

Primary Insurance

Person Responsible for Account:

Last Name:_____ First Name:_____ MI:____

Relation to Patient:_____ Birthdate:_____ SS/HIC/Patient ID #:_____

Mailing Address (if different from patient):_____ Phone Number:_____

City:_____ State:_____ Zip Code:_____

Person Responsible Employed By:_____ Occupation:_____

Business Address:_____ Business Phone:_____

Insurance Company:_____

Contract #:_____ Group #:_____ Subscriber #:_____

Names of other dependents covered under this plan:_____

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Additional Insurance

Is patient covered by additional insurance?: ☐ Yes ☐ No

Subscriber Name:_____ Relation to Patient:_____ Birthdate:_____

Mailing Address (if different from patient):_____ Phone Number:_____

City:_____ State:_____ Zip Code:_____

Subscriber Employed By:_____ Business Phone:_____

Insurance Company:_____ SSN:_____

Contract #:_____ Group #:_____ Subscriber #:_____

Names of other dependents covered under this plan:_____

Dental History

Reason for Today's Visit:_____ Date of Last Dental Care:_____

Former Dentist:_____ Date of Last Dental X-Rays:_____

Mailing Address:_____

Check if you have had problems with any of the following:

☐ Bad breath	☐ Bleeding gums	☐ Clicking or popping jaw	☐ Grinding teeth
☐ Sensitivity to hot	☐ Loose teeth or broken fillings	☐ Periodontal treatment	☐ Sensitivity to sweets
☐ Sensitivity when biting	☐ Food collection between teeth	☐ Sensitivity to cold	☐ Sores or growths in your mouth

How often do you floss?:_____ How often do you brush?:_____

Medical History

Physician's Name:_____ Date of Last Visit:_____

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 (dexfenfluramine)?: ☐ Yes ☐ No

Have you had any serious illnesses or operations?: ☐ Yes ☐ No If yes, describe:_____

Have you ever had a blood transfusion?: ☐ Yes ☐ No If yes, give approximate dates:_____

(Women) Are you pregnant?: ☐ Yes ☐ No Nursing?: ☐ Yes ☐ No Taking birth control pills?: ☐ Yes ☐ No

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Medical History (continued)

Check if you have or have had any of the following:

- ☐ Anemia
- ☐ Cortisone Treatments
- ☐ Arthritis, Rheumatism
- ☐ Cough, Persistent
- ☐ Artificial Heart Valves
- ☐ Cough up Blood
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

MEDICATIONS: List medications you are currently taking:_____

Allergies:_____

Authorization

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Fulmer 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 dentist 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 for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Patient or Guardian Signature:_____ Date:_____