Dean L. Wahl, D.D.S.

105 Warren Street, Beaver Dam, WI 53916
Phone: 920-887-1432

Patient's Name (Ms., Miss, Mrs., Mr.) _____

Address: _____ **City:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____

Work Phone: _____ **Name of Employer:** _____

E-mail Address: _____ **Date of Birth** _____

Gender (M / F) Marital Status: _____ **Do you have dental insurance? Yes ___ No ____**

Medical History

Physician's Name _____ **City:** _____

Are you under medical care at the present time? **No _____** **Yes _____**

If so, what reason? _____

What medications are you taking (prescription or nonprescription)? _____

High blood pressure	**No**	**Yes**	**Low blood pressure**	**No**	**Yes**
Epilepsy	**No**	**Yes**	**Tuberculosis**	**No**	**Yes**
Blood diseases	**No**	**Yes**	**Venereal diseases**	**No**	**Yes**
Cancer	**No**	**Yes**	**Diabetes**	**No**	**Yes**
Heart surgery	**No**	**Yes**	**Hepatitis (Jaundice)**	**No**	**Yes**
Sinus problems	**No**	**Yes**	**Headaches**	**No**	**Yes**
Canker sores	**No**	**Yes**	**Fainting Spells**	**No**	**Yes**
Cold sores	**No**	**Yes**	**Kidney Problems**	**No**	**Yes**
Chronic bronchitis	**No**	**Yes**	**Arthritis**	**No**	**Yes**
Emphysema	**No**	**Yes**	**Bleeding problem**	**No**	**Yes**
Heart murmur	**No**	**Yes**	**AIDS/HIV**	**No**	**Yes**
Valve replacement	**No**	**Yes**	**Blood transfusions**	**No**	**Yes**
Joint replacement	**No**	**Yes**	**Eating disorders**	**No**	**Yes**
Asthma	**No**	**Yes**	**Rheumatic fever**	**No**	**Yes**
Radiation Therapy	**No**	**Yes**	**Allergies**	**No**	**Yes**

If so, what allergies: _____

Have you been hospitalized in the past five years? **No _____** **Yes _____**

If yes, when and why? _____

Dental History

Previous Dentist's Name: _____ City: _____

Last visit to a dentist: _____ Treatment Received: _____

Date of last prophylaxis (cleaning): _____ Date of last x-rays: _____

How often do you brush your teeth? _____

How often do you floss your teeth? _____

Have you ever had any of the following?

Orthodontic treatment:	**No**	**Yes**
Periodontal gum surgery:	**No**	**Yes**
Hypersensitive teeth	**No**	**Yes**
Accidental injuries to teeth, mouth, jaw	**No**	**Yes**

Do you have any of the following habits?

Smoking, chewing tobacco:	**No**	**Yes**
Nail biting	**No**	**Yes**
Thumb or finger sucking	**No**	**Yes**
Chewing on pens, pencils, or ice	**No**	**Yes**
Other habits:	**No**	**Yes**

What? _____

To my knowledge, all of the above information is correct. I hereby consent to such examination, x-rays, and diagnostic procedures and tests you may prescribe. I understand it is my responsibility to inform you of any medical or other changes that need to be made.

In case of an emergency, notify _____ Phone # _____

***** If other contact is unavailable list someone other than a family.**

Provide another name: _____ Phone # _____

If under eighteen years of age, parent/guardian must sign. Indicate your relationship to patient:

Signature: _____ Date _____

I acknowledge that I have received a "Notice of Privacy Practices" information form from Dr. Dean L. Wahl.

Signature: _____ Date _____