

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 ___

How did you hear about our office? _____

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 _____