Dr. Mark Sitzman • Dr. Michael Wolf
320 W. Buena Vista • Evansville, IN 47710
(812) 423-6662

## Patient Information

**Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.**

Chart # ______________________
FOR OFFICE USE ONLY

Patient Name ______________________________________________________________
LAST FIRST MI PREFERRED NAME

Mr / Ms / Mrs / etc Gender: ❑ Male ❑ Female Family Status: ❑ Married ❑ Single ❑ Child ❑ Other

Birth Date: ____________________ Age __________ SS# __________-__________-______________

Email Address: ______________________________________________________________

Phone: (_____) ____________________ (_____) ____________________ ________ (_____) ____________________
HOME WORK EXT MOBILE

Address: ______________________________________________________________

______________________________________________________________
CITY STATE ZIP CODE

**In case of emergency, who should be notified?** ________________________________

**Phone # (_______)____________________ Relationship to Patient** ____________________

Whom may we thank for referring you to our practice? ❑ Dr. Referral ❑ Patient Referral ❑ Internet Referral

Name of person or office referring you to our practice ________________________________

## Spouse or Responsible Party Information

The following is for: ❑ the patient's spouse ❑ the person responsible for payment ❑ neither - not applicable

Name ______________________________________________________________
LAST FIRST MI PREFERRED NAME

Mr / Ms / Mrs / etc Gender: ❑ Male ❑ Female Family Status: ❑ Married ❑ Single ❑ Child ❑ Other

Birth Date: ____________________ SS# ________-________-______________ Driver's License # ______________

Email Address: ________________________________Best time to call: ____________________

Phone: (_____) ____________________ (_____) ____________________ ________ (_____) ____________________
HOME WORK EXT MOBILE

Address: ______________________________________________________________

______________________________________________________________
CITY STATE ZIP CODE

## Employment Information

The following is for: ❑ the patient ❑ the person responsible for payment

Employer Name: ______________________________ Phone: (_______) ______________

Address: ______________________________________________

______________________________________________
CITY STATE ZIP CODE

## Primary Dental Insurance Information

Name of Insured: ______________________________________________
LAST FIRST MI

Insured's Birth Date: ______________ ID #: ______________ Group #: ______________

Insured's Address: ______________________________________________

______________________________________________
CITY STATE ZIP CODE

Insured's Employer Name ______________________________________________

Employer Address: ______________________________________________

______________________________________________
CITY STATE ZIP CODE

Patient's relationship to insured: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insurance Plan Name: ______________________________________________

Insurance Address: ______________________________________________

______________________________________________
CITY STATE ZIP CODE

## Secondary Dental Insurance Information - If Applicable

Name of Insured: ______________________________________________
LAST FIRST MI

Insured's Birth Date: ______________ ID #: ______________ Group #: ______________

Insured's Address: ______________________________________________

______________________________________________
CITY STATE ZIP CODE

Insured's Employer Name ______________________________________________

Employer Address: ______________________________________________

______________________________________________
CITY STATE ZIP CODE

Patient's relationship to insured: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insurance Plan Name: ______________________________________________

Insurance Address: ______________________________________________

______________________________________________
CITY STATE ZIP CODE

## Health History

| | | | |
|---|---|---|---|
| _____ Allergies | _____ Dizziness | _____ HIV | _____ Respiratory Problems |
| _____ Alzheimer's Disease | _____ Epilepsy | _____ Jaundice | _____ Rheumatic Fever |
| _____ Anemia | _____ Excessive Bleeding | _____ Kidney Disease | _____ Rheumatism |
| _____ Arthritis | _____ Fainting | _____ Latex Allergy | _____ Sinus Problems |
| _____ Artificial Joints | _____ Glaucoma | _____ Liver Disease | _____ Stomach Problems |
| _____ Asthma | _____ Growths | _____ Mental Disorders | _____ Stroke |
| _____ Autism | _____ Hay Fever | _____ Multiple Sclerosis | _____ Tuberculosis |
| _____ Blood Disease | _____ Head Injuries | _____ Nervous Disorders | _____ Tumors |
| _____ Cancer | _____ Heart Disease | _____ NO Epinephrine | _____ Ulcers |
| _____ Codeine Allergy | _____ Heart Murmur | _____ Pacemaker | _____ Venereal Disease |
| _____ COPD | _____ Heart Problems | _____ Parkinson's Disease | _____ Other |
| _____ Coumadin | _____ Hepatitis | _____ Penicillin Allergy | Anything not listed above |
| _____ Diabetes | _____ High Blood Pressure | _____ Radiation Treatment | |

Name of Physician ________________________________________ Date of last physical ________________

Are you on any medications at this time? If so, please list. ________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Women - Are you pregnant? ____________ If so, delivery date? ____________________

Are you taking or scheduled to begin taking an antiresorptive agent (Fosamax, Actonel, Ateivia, Boniva, Reclast, Prolia, etc.) for osteoporosis or Paget's disease? _____Yes _____ No

Has a physician or previous dentist recommended that you take antibiotics due to joint replacement or heart issues prior to dental appointments? ____Yes ____No

If so, name of physician and antibiotics ________________________________________________

Are you allergic to or have had a reaction to any of the following?

| | | |
|---|---|---|
| _____ Local Anesthetics | _____ Sulfa | _____ Metals |
| _____ Aspirin | _____ Codeine or other narcotics | _____ Dyes |
| _____ Penicillin or other antibiotics | _____ Latex (rubber) | _____ Other ____________________ |

Any present dental issues?

| | | |
|---|---|---|
| _____ Bleeding Gums | _____ Sores or Ulcers | _____ Grinding |
| _____ Clicking or popping in jaw | _____ Dry Mouth | _____ Sensitive to temperature or pressure |

Do you use tobacco products? _____Yes _____ No

Do you have any sleep disorders? ___Yes ___ No • Do you snore? ___Yes ___ No • Do you use a CPAP? ___Yes ___ No

Date of last dental cleaning ________________________________ Date of last dental x-rays ________________________________

Do you wear any dental appliances? ________________________________________________________________________________
(Partial or full dentures, night guard or retainer)

Have you ever had any periodontal (gum) treatments? _____Yes _____ No

If yes, which periodontist have you seen? ____________________________________________________________________________

Are you currently under the care of an orthodontist? _____Yes _____ No

If yes, who is your orthodontist? _________________________________________________________________________________

How important is your smile to you? ______________________________________________________________________________

**Note: Both doctor and patient are encouraged to discuss any and all relevant health issues prior to treatment.** I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

**Office policy regarding payment for services: Payment is due in full the day services are rendered unless arrangements are made. We will provide all necessary documentation to your insurance company at no fee; however, we cannot be responsible for knowing the amount paid. Past due balances are subject to a 1½% per month service charge. In the event legal process is necessary to collect the balance due, patient agrees to pay all costs incurred including, but not limited to, a reasonable attorney fee.**

Signature ____________________________________________________________ Date ___________________________________

If this form is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative’s Name ___________________________________________________________________________

Relationship to Patient _________________________________________________________________________________