DATE ____________

# GEARY DENTISTRY, LLC

12780 WEST NORTH AVENUE • BROOKFIELD, WI 53005

(262) 860-1500

## *We would like to get to know you better!*

NAME ____________

ADDRESS ____________

CITY, STATE, ZIP ____________

HOME PHONE (____) ____________

DATE OF BIRTH ____________

MARITAL STATUS ____________

WHOM MAY WE THANK FOR REFERRING YOU? ____________

EMAIL ____________

EMPLOYER/OCCUPATION ____________

BUSINESS PHONE (____) ____________

CELL PHONE (____) ____________

SPOUSE'S NAME ____________

SPOUSE'S EMPLOYER/OCCUPATION ____________

PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT ____________

### PRIMARY DENTAL INSURANCE INFORMATION:

POLICYHOLDER'S NAME ____________

POLICYHOLDER'S DATE OF BIRTH ____________

INSURANCE COMPANY ____________

INSURANCE COMPANY TELEPHONE ____________

EMPLOYER ____________

SOCIAL SECURITY NUMBER ____________

POLICY # ____________ GROUP # ____________

### SECONDARY DENTAL INSURANCE INFORMATION:

POLICYHOLDER'S NAME ____________

POLICYHOLDER'S DATE OF BIRTH ____________

INSURANCE COMPANY ____________

INSURANCE COMPANY TELEPHONE ____________

EMPLOYER ____________

SOCIAL SECURITY NUMBER ____________

POLICY # ____________ GROUP # ____________

## DENTAL HISTORY

WHAT IS THE MAIN REASON FOR THIS VISIT? ____________

ARE YOU HAVING ANY SPECIFIC DENTAL PROBLEMS? ☐ YES ☐ NO DESCRIBE ____________

DATE OF YOUR LAST DENTAL EXAM: ___/___/___ PROFESSIONAL CLEANING: ___/___/___ FORMER DENTIST'S NAME: ____________

HOW OFTEN DO YOU BRUSH? ____________ FLOSS? ____________

ARE YOUR TEETH SENSITIVE TO: ☐ HOT ☐ COLD ☐ SWEETS ☐ CHEWING ☐ NOTHING WHERE? ____________

HAVE YOU BEEN SHOWN THE PROPER WAY TO BRUSH AND FLOSS? ☐ YES ☐ NO

DO YOUR GUMS BLEED? ☐ YES ☐ NO WHEN? ____________

DOES FOOD CATCH BETWEEN YOUR TEETH? ☐ YES ☐ NO WHERE? ____________

ARE ANY OF YOUR TEETH SENSITIVE? ☐ YES ☐ NO WHERE? ____________

DO YOU FEEL NERVOUS ABOUT HAVING ANY DENTAL TREATMENT? ☐ YES ☐ NO

HAVE YOU EVER BEEN TOLD THAT YOU HAVE PERIODONTAL (GUM) DISEASE? ☐ YES ☐ NO

HAVE YOU EVER BEEN REFERRED FOR OR UNDERGONE PERIODONTAL (GUM) SURGERY? ☐ YES ☐ NO

HAVE YOU EVER BEEN TOLD YOU NEED TO PREMEDICATE PRIOR TO DENTAL APPOINTMENTS? ☐ YES ☐ NO

DO YOU HAVE ANY REMOVABLE APPLIANCE(S) IN YOUR MOUTH? ☐ YES ☐ NO

☐ FULL DENTURE ☐ PARTIAL DENTURE ☐ NIGHT GUARD ☐ OCCLUSAL SPLINT ☐ RETAINER ☐ OTHER ____________

ARE YOU SATISFIED WITH THE WAY YOUR TEETH LOOK? FOR EXAMPLE: COLOR, SHAPE, SPACES, ETC. ☐ YES ☐ NO

EXPLAIN ____________

## JAW RELATED PROBLEMS

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING:

☐ PAIN IN/AROUND EARS

☐ PAIN WHEN CHEWING, YAWNING

☐ DIFFICULTY OPENING/CLOSING MOUTH

☐ PAIN WHEN OPENING WIDE

☐ PREVIOUS TREATMENT FOR JAW PROBLEMS OR TMJ

☐ JAW JOINT NOISES

☐ JAW MUSCLES TENDER

☐ PREVIOUS ORTHODONTIC TREATMENT

***- PLEASE COMPLETE BACK SIDE -***

# MEDICAL HISTORY

NAME OF PHYSICIAN ______________________ DR. TELEPHONE ( ______ ) ______________

ADDRESS OF PHYSICIAN ______________________________

DATE OF LAST PHYSICAL EXAM ____/____/____ ☐ ROUTINE ☐ ILLNESS ______________

HAVE YOU BEEN HOSPITALIZED IN THE LAST FIVE YEARS? ☐ YES ☐ NO REASON ______________

ARE YOU UNDERGOING ANY MEDICAL TREATMENT? ☐ YES ☐ NO DESCRIBE ______________

ARE YOU PRESENTLY TAKING ANY MEDICATION? ☐ YES ☐ NO DESCRIBE ______________

HAVE YOU EVER HAD A REACTION TO A MEDICATION? ☐ YES ☐ NO EXPLAIN ______________

ARE YOU ALLERGIC TO: ☐ PENICILLIN ☐ ASPIRIN ☐ LOCAL ANESTHETIC ☐ IODINE ☐ OTHER MEDICATIONS

ARE YOU CURRENTLY, OR HAVE YOU EVER TAKEN BISPHOSPHONATES (BONE DENSITY MEDICATION)? ☐ YES ☐ NO

DO YOU BLEED ABNORMALLY AFTER CUTS OR EXTRACTIONS? ☐ YES ☐ NO

DO YOU SMOKE OR USE SMOKELESS TOBACCO? ☐ YES ☐ NO HOW MUCH? ______________

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING:

| | | | | |
|---|---|---|---|---|
| ☐ AIDS / HIV+ | ☐ CANCER | ☐ FATIGUE EASILY | ☐ INFECTIOUS DISEASE | ☐ PSYCHIATRIC CARE |
| ☐ ALCOHOL ADDICTION | ☐ CHEMOTHERAPY | ☐ GLAUCOMA | ☐ INTESTINAL PROBLEMS | ☐ RHEUMATIC FEVER |
| ☐ ANEMIA | ☐ CHEST PAIN | ☐ HEARING PROBLEM | ☐ JOINT REPLACEMENTS | ☐ SHORT OF BREATH |
| ☐ ANKLES SWELL | ☐ COLD SORES | ☐ HEART DISEASE | ☐ KIDNEY DISEASE | ☐ STROKE |
| ☐ ARTHRITIS | ☐ DIABETES | ☐ HEART MURMUR | ☐ LATEX ALLERGY | ☐ T.B. |
| ☐ ARTIFICIAL HEART VALVE | ☐ DRUG ADDICTION | ☐ HEART SURGERY | ☐ LIVER DISEASE | ☐ TUMOR(S) |
| ☐ ASTHMA | ☐ EPILEPSY | ☐ HEPATITIS A, B, C | ☐ MITRAL VALVE PROLAPSE | ☐ THYROID DISEASE |
| ☐ BLOOD DISEASE | ☐ EMPHYSEMA | ☐ HERPES I, II | ☐ MONONUCLEOSIS | ☐ ULCER(S) |
| ☐ BRUISE EASILY | ☐ FAINTING | ☐ HIGH BLOOD PRESSURE | ☐ PACEMAKER | ☐ VENEREAL DISEASE |

ARE THERE ANY OTHER PHYSICAL, MENTAL OR EMOTIONAL PROBLEMS WE SHOULD BE AWARE OF? ☐ YES ☐ NO

WOMEN, ARE YOU: ☐ PREGNANT ☐ TAKING BIRTH CONTROL PILLS

______________________________

PATIENT ______________________ DR./STAFF ______________________ ____/____/____
SIGNATURE SIGNATURE

I GIVE DR. GEARY PERMISSION TO USE MY PHOTOGRAPHS/X-RAYS FOR THE PURPOSE OF EDUCATION/MARKETING. ☐ YES ☐ NO

______________________________ ____/____/____
SIGNATURE DATE

PLEASE DO NOT WRITE BELOW THIS LINE

## HEALTH REVIEW

| DATE | CHANGES | BP | DR/STAFF | DATE | CHANGES | BP | DR/STAFF |
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MARY EILEEN GEARY, D.D.S.
TERENCE P. GEARY, D.D.S.

# CHILD REGISTRATION

Patient's Name ______________________
Today's date ______________________
Child likes to be called ______________________
Age ____________ Date of birth ______________________
Parent's Names ______________________
City ______________ State ______ Zip ____________
Address ______________________
Home phone number ______________________
Father's occupation ______________________
Employer ______________________
How long held? ______________________
Work phone ______________________
Mother's occupation ______________________
Employer ______________________
How long held? ______________________
Work phone ______________________
Person responsible for this account ______________________
Purpose of visit ______________________
Whom may we thank for this referral? ______________________
May we confirm appointments at your place of business?

Yes ☐ No ☐

Does your child have a favorite toy or pet? ______________________
Are there any other children in the family? ______________________
Their ages are ______________________
Patient's school ______________________

*It is important that we know about your Medical and Dental History.*
*These facts have direct bearing on your Dental Health. This information will remain confidential.*
*Thank you for taking the time to completely answer all questions.*

| MEDICAL HISTORY | YES | NO |
|---|---|---|
| Does your child have any Health Problems? | ☐ | ☐ |
| Is your child under a Physician's care now? | ☐ | ☐ |
| For what? ______________________ | | |
| Is your child currently taking any medication? | ☐ | ☐ |
| If yes, what? ______________________ | | |
| Is your child Allergic to any medication? | ☐ | ☐ |
| If yes, please list ______________________ | | |
| Physician's Name ______________________ | | |
| Address ______________________ | | |

Circle any of the following which your child has had or has now.

Diabetes
Asthma
Heart Trouble
Rheumatic Fever
Hemophilia
Epilepsy
Hepatitis
Abnormal Bleeding
A.I.D.S.
Artificial Joints
Physical or Emotional Problems
Other ______________________

| DENTAL HISTORY | YES | NO |
|---|---|---|
| Is this your child's first visit to the dentist? | ☐ | ☐ |
| If not, when was previous visit? ______________________ | | |
| What was done? ______________________ | | |
| Does your child eat a well balanced diet? | ☐ | ☐ |
| Does your child eat between meals? | ☐ | ☐ |
| What type of snacks? ______________________ | | |
| Do you have fluoridated water in the home? | ☐ | ☐ |
| Who brushes child's teeth? ______________________ | | |
| When? ______________________ | | |
| Is child bothered by the thought of having Dentistry? | ☐ | ☐ |
| Does child have any thumb or finger sucking habits? | ☐ | ☐ |
| Explain ______________________ | | |

12780 W. North Avenue    Brookfield, WI 53005
262-860-1500

FORM 124729 R/09/03 ITEM 8101 COLWELL SYSTEMS 1.800.637.1140

## DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name ____________________

Insured's date of birth ____________________

Insurance Company ____________________

Insurance Company Address ____________________

Insurance Company Telephone ____________________

Employer ____________________

Program or Policy Number ____________________

Union Local or Group ____________________

Insured's social security number ____________________

**If you have additional insurance coverage, complete for second coverage.**

Insured's Name ____________________

Insured's date of birth ____________________

Insurance Company ____________________

Insurance Company Address ____________________

Insurance Company Telephone ____________________

Employer ____________________

Program or Policy Number ____________________

Union Local or Group ____________________

Insured's social security number ____________________

## CONSENT:

*The undersigned hereby authorizes Dr. Geary or his designated assistant to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by Dr. Geary to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Geary to perform any and all forms of treatment, medication and therapy that may be indicated.*

*I also assign insurance benefits to Dr. Geary.*

Parent's Signature ____________________ Date ____________________

Please do not write below this line

## HEALTH REVIEW

| Date | Changes | Dr/Staff | Date | Changes | Dr/Staff |
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