ELITE SMILES
DENTAL LTD
315 W. Wisconsin Ave Appleton, WI 54911
www.EliteSmilesWisconsin.com

ALISSA M. EDWARDS, DDS
920-731-2211
MARK PFLUM, DDS
920-733-8309
DALE M. SCHARINE, DDS
920-733-4787

About You

Today's Date _____

Patient Name

_____
Last First M

What You Prefer to be Called _____
Birthdate _____ Age _____
Social Security # _____
Mailing Address _____

_____
City State Zip

Home Phone # _____
Work Phone # _____
Cell Phone # _____
e-mail Address _____
Patient Contact Preference
☐ Text ☐ Phone ☐ Email
Referred By _____

Employer _____
Employer's Address _____

_____
City State Zip

Employer Phone # _____
Occupation _____

Status: Single___ Married___ Divorced___ Widowed___

Spouse's Name _____

Do you have children? Yes___ No___ How many? _____

Account Information

Person responsible for account

Name _____
Relationship _____
Billing Address _____

_____
City State Zip

Social Security # _____
Drivers License # _____
Work Phone # _____
Home Phone # _____

Insurance Information

Primary Dental Insurance

Insurance Carrier _____
Insurance Co. Address: _____
Group Plan # _____
Phone # _____
Insured's Name _____
Relation _____
Date of Birth _____
Insured's SS# _____
Insured's Employer _____
Subscriber ID # _____

Secondary Dental Insurance

Insurance Carrier _____
Insurance Co. Address: _____
Group Plan # _____
Phone # _____
Insured's Name _____
Relation _____
Date of Birth _____
Insured's SS# _____
Insured's Employer _____
Subscriber ID # _____

In Event of Emergency

Who should we contact? _____
Relationship: _____
Home Phone # _____
Work Phone # _____
Cell Phone # _____
Who is your Medical Dr / Pediatrician / Family Dr?

_____
M.D.'s Phone # _____

Please continue on back →

Are you allergic to any of the following?
Latex___Penicillin___Amoxicillin___Aspirin___Ibuprofen___Metal___or any reaction to a substance or medication not listed?_____

Have you ever had a reaction after receiving dental anesthetic? Yes ___ No___
Explain reaction:_____

HAVE YOU BEEN HOSPITALIZED WITHIN THE PAST YEAR? YES ___ NO ___
For What Condition?_____

Please circle yes or no to the following medical conditions & date when the condition occurred:

			Date				Date				Date
High Cholesterol	Y	N	_____	GERD	Y	N	_____	Rheumatic Fever	Y	N	_____
Heart Attack/Failure	Y	N	_____	Drug / Alcohol Abuse	Y	N	_____	Shingles	Y	N	_____
Stroke	Y	N	_____	Tobacco Use	Y	N	_____	Thyroid Problems	Y	N	_____
Heart Surgery	Y	N	_____	What type _____ how often _____				Cold Sores/Canker Sores	Y	N	_____
Angina / Chest Pain	Y	N	_____	HIV/AIDS	Y	N	_____	Herpes	Y	N	_____
Heart Murmur	Y	N	_____	Cancer / Tumors	Y	N	_____	Venereal Disease	Y	N	_____
Pacemaker / Defibrillator	Y	N	_____	Chemotherapy	Y	N	_____	Blood Transfusion	Y	N	_____
Congenital Heart Defect	Y	N	_____	Radiation Treatment	Y	N	_____	Fainting/Dizzy	Y	N	_____
Artificial Valves	Y	N	_____	Leukemia	Y	N	_____	Epilepsy/Seizures	Y	N	_____
Mitral Valve Prolapse	Y	N	_____	Osteoporosis	Y	N	_____	SARS	Y	N	_____
High / Low Blood Pressure	Y	N	_____	Artificial Joints	Y	N	_____	Glaucoma	Y	N	_____
Arteriosclerosis	Y	N	_____	Arthritis	Y	N	_____	Developmentally Disabled	Y	N	_____
Allergies/Hives	Y	N	_____	Rheumatism	Y	N	_____	Sickle Cell Disease	Y	N	_____
Asthma	Y	N	_____	Jaw Problems / TMJ	Y	N	_____	Ulcers	Y	N	_____
Breathing Problems	Y	N	_____	Fibromyalgia	Y	N	_____	West Nile	Y	N	_____
Respiratory Disease (Emphysemia)	Y	N	_____	Bleeding Problems	Y	N	_____	Cortisone Medicine	Y	N	_____
Sinus Problems	Y	N	_____	Diabetes / Hypoglycemia	Y	N	_____	Travel Internationally	Y	N	_____
Tuberculosis TB	Y	N	_____	Hepatitis (List A/B/C)	Y	N	_____	Psychiatric Treatments	Y	N	_____
Sleep Apnea	Y	N	_____	Kidney Disease	Y	N	_____	Anxiety/Depression	Y	N	_____
Eating Disorders	Y	N	_____	Liver Disease	Y	N	_____	Cosmetic Surgery/Botox	Y	N	_____

Please list any medical conditions we should know that are not listed above:

_____

Please list any medications you are currently taking (including herbal medications, vitamins & supplements):

_____

_____

Are you pregnant? Yes___ No___ What month_____ Are you nursing? Yes___No___

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collection of your unpaid balance.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims; for additional specialist consultation; or in the event I request my records to be transferred to another dental office.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature_____ Date_____

☐ Adult Patient ☐ Parent or Guardian ☐ Spouse