George L. Hess III DDS
3003 Superior Ave.
Sheboygan, WI 53081

Name:________________ Prefer to Be Called:____________ Date of Birth:__________

Address:________________ City:__________ Zip:________ S.S.#:____________

Home Phone: __________ Work Phone:__________ Ext. or Dept.:_____ Cell Phone:__________

Place of Employment:____________________ Address: ____________________

E-mail Address:________________ Children's Names, if Any: ________________

Name of Spouse if Married: ____________ S.S. # ____________ Date of Birth:__________

Spouse Employed By:____________________ Address: ____________________

Spouse's Work Phone: ____________________ Ext. or Department:______________

Whom may we thank for referring you to our office? ____________________________

Whom may we contact in case of an emergency?____________________Phone:____________

To ensure your well being while undergoing treatment in our office, please answer the following questions in detail.
All information will be considered confidential and for our records only.

Health Information

Do you now have or have you had any of the following diseases or problems?

Cardiovascular Disease? ❑ Yes ❑ No
If yes, check any that apply:

❑ Heart Disease ❑ Hardening of the arteries
❑ Heart attack ❑ High blood pressure
❑ Coronary bypass ❑ Angina
❑ Stroke ❑ Heart Murmur
❑ Mitral valve prolapse ❑ Congestive heart failure

Yes	No	
❑	❑	Rheumatic fever/rheumatic heart disease
❑	❑	Congenital heart defects
❑	❑	Prosthetic (artificial) heart valves
❑	❑	Pacemaker? If yes, date placed________
❑	❑	High blood pressure
❑	❑	High cholesterol
❑	❑	Do you have chest pain upon exertion?
❑	❑	Abnormal bleeding or excessive bleeding
❑	❑	Do you have an artificial joint?

If yes, which joint(s)______________________

When was your last complete exam with your medical physician?__________________________
Physician Name:______________________________

Diabetes? Yes No
If yes, do you require insulin? ❑ ❑
Type and Dose______________________________

Hepatitis? ❑ ❑
If yes, check type:

❑ Type A ❑ Other
❑ Type B ❑ Non-Specific Type
❑ Type C ❑ Don't know

	Yes	No
Have you ever required a blood transfusion? If yes, what was the date of the transfusion?______	❑	❑
Are you presently seeing a physician for a recent or ongoing medical condition?	❑	❑
Have you been hospitalized within the last year? If yes, please explain:________________________	❑	❑
Have you ever been advised to take antibiotics before a dental appointment? If yes, please explain:______________________	❑	❑

over →

Please Check All That Apply:

- ❑ Allergies
- ❑ Alzheimer's Disease
- ❑ Anemia
- ❑ Angina
- ❑ Asthma
- ❑ Arthritis
- ❑ Autoimmune Disease
- ❑ Blood Disorder
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Chronic Sinus Problems
- ❑ Cirrhosis
- ❑ Depression
- ❑ Diabetes
- ❑ Drug or Alcohol Treatment
- ❑ Eating Disorder
- ❑ Epilepsy or Other Seizures
- ❑ Glaucoma
- ❑ Heart Disease
- ❑ Herpes
- ❑ HIV/AIDS
- ❑ Jaundice/Liver Disease
- ❑ Joint Replacement
- ❑ Kidney Disease
- ❑ Organ Transplant
- ❑ Osteoporosis
- ❑ Parkinson's Disease
- ❑ Radiation Treatment
- ❑ Respiratory Problems
- ❑ Serious/Frequent Headaches
- ❑ Sexually Transmitted Disease
- ❑ Skin Problems
- ❑ Thyroid Problem
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Other_________________

If you are *currently* taking these medications, check the box on the left. If you have taken any of these medications within the *past year,* but are not taking them currently, check the box on the right.

Now	Past Year	
❑	❑	Antibiotics
❑	❑	Antidepressants(Prozac, Zoloft, etc)
❑	❑	Antihistamines
❑	❑	Blood Pressure Medicine
❑	❑	Blood Thinners
❑	❑	Cortisone (Prednisone etc)
❑	❑	Cholesterol Medication
❑	❑	Decongestants
❑	❑	Diuretics (water pills)
❑	❑	Hormones (birth control pills, estrogen)
❑	❑	Inhalants
❑	❑	Insulin
❑	❑	Medicine for Heart Problems
❑	❑	Muscle Relaxants
❑	❑	Niroglycerine
❑	❑	Pain Medicine (Advil, Aspirin, Tylenol, etc)
❑	❑	Prescription Pain Medication
❑	❑	Sleeping Pills
❑	❑	Thyroid Medicine
❑	❑	Tranquilizers
❑	❑	Vitamins
❑	❑	Others________________________________

Please list the names of any drugs you are currently taking: ____

____

Are you *allergic* to any of the following medications (do you get hives, a rash, have trouble breathing, etc.):

- ❑ Latex
- ❑ Antibiotics (penicillin, tetracycline, etc.)
- ❑ Local Dental Anesthetics (novacaine)
- ❑ Codeine
- ❑ Aspirin
- ❑ Barbituates or Sedatives
- ❑ Tranquilizers
- ❑ Others____________________________

Have you ever had an adverse reaction like nausea to a drug or medication? ❑ Yes ❑ No

Do you have any disease or condition not previously listed that you feel we should know about? ❑ Yes ❑ No
If yes, please explain:____

Do you now or have you ever smoked? ❑ Yes ❑ No
If yes, please circle: Cigarettes Pipe Cigar Other______________ If you currently smoke, how much?____________
Do you chew tobacco? ❑ Yes ❑ No
If yes, how often?___________________________

Women

Are you pregnant? ❑ Yes ❑ No Due Date: __________ Are you nursing? ❑ Yes ❑ No

Signature:____ **Date:**______________________________

Dental History

Why have you made this dental appointment? ______________________________

How long since your last dental visit? ______________________________

What was the nature of that appointment? ______________________________

Name of previous dentist: ______________________________

Why have you decided to change dentists? ______________________________

Date of last complete dental x-ray series: ______________________________

Are you in any discomfort at this time? ❑ Yes ❑ No If yes, please explain: ____________

Do you normally see a dentist on a routine basis? ❑ Yes ❑ No

Do you feel apprehensive about having dental treatment? ❑ Yes ❑ No

Do you have any pain in your teeth because of heat, cold, or sweets? ❑ Yes ❑ No If so, where? ____________

Do you have pain in any tooth while biting or chewing? ❑ Yes ❑ No If so, where? ____________

Have you experienced pain in or near your ear? ❑ Yes ❑ No If yes, when? ____________

Have you lost any teeth or have any teeth been removed? ❑ Yes ❑ No If so, why? ____________

Have the missing teeth been replaced? ❑ Yes ❑ No If yes, when? ____________

Are you happy with the replacements? ❑ Yes ❑ No If no, please explain: ____________

Do you grind or clench your teeth? ❑ Yes ❑ No

Have you had orthodontic work? ❑ Yes ❑ No

Have you had any periodontal treatment? ❑ Yes ❑ No If yes, when was the most recent treatment? ____________

Type of treatment: (circle all that apply) Gingivitis cleaning Deep cleaning Gum Surgery

Do your gums feel irritated, tender, or swollen when eating, brushing or flossing? ❑ Yes ❑ No

How often do you brush? ____________ How often do you floss? ____________

Do you brush with a fluoride toothpaste? ❑ Yes ❑ No

Is there fluoride in your drinking water? ❑ Yes ❑ No

Do you use a hard or soft toothbrush? ____________

Do you drink any sweetened beverages/soda (regular or diet) between meals? ❑ Yes ❑ No

If yes, how much per day? ____________

Are you whitening your teeth currently? ❑ Yes ❑ No

If not, would you be interested in making your teeth whiter? ❑ Yes ❑ No

If you could change anything about your smile, what would it be? ____________

On a scale from 1 to 10:

How do you rate your current dental health? ________ 1 = poor 10 = excellent

How important is your dental health to you? ________ 1 = not important 10 = very important

Please indicate whether you have/had or do the following:

Bad Breath	❑ Yes ❑ No	Clicking or Popping Jaw	❑ Yes ❑ No
Oral Surgery	❑ Yes ❑ No	Food Collection Between the Teeth	❑ Yes ❑ No
Mouth Breathing	❑ Yes ❑ No	Difficulty Opening/Closing	❑ Yes ❑ No
Jaw Pain or Tenderness	❑ Yes ❑ No	Loose Teeth or Broken Fillings	❑ Yes ❑ No

Release Information

The information present on these pages is true to the best of my knowledge. The undersigned authorizes Dr. George Hess III to take X-rays, study models, photographs, or other diagnostic materials deemed appropriate by Dr. Hess to make a thorough diagnosis of my dental health condition. I authorize Dr. Hess to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the services required for my dental health. I understand Dr. Hess will discuss treatment before beginning. I further authorize and consent Dr. Hess to choose and employ such assistance as deemed fit.

I request that payment of authorized insurance benefits be made directly to Dr. George L Hess III for services provided to me from his dental facility. I authorize the release of any information needed to determine these benefits or the benefits payable for related services.

I understand that the responsibility for payment for professional services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless written financial arrangements have been made. In the event of default, I promise to pay interest on the indebtedness, together with any collection costs and attorney fees as may be required to effect collection. Accounts 30 days past due are assessed 1.5% per month.

Signature ______________________________ **Date** ____________