HESS
DENTAL CARE

3003 Superior Ave – Sheboygan, WI 53081
920.452.9953
www.hessdentalcare.com email: staff@hessdentalcare.com

Name:_____ Prefer to Be Called:_____ Date of Birth:_____

Address:_____ City:_____ State:_____ Zip:_____

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

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

Place of Employment:_____ Address: _____

Name of Spouse if Married: _____ Date of Birth:_____

Spouse Employed By:_____ Address: _____

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

Whom may we contact in case of an emergency? _____Phone:_____

How can we help you today?_____

Your current dental health is: Good ☐ Fair ☐ Poor ☐

Are you currently in pain? Yes ☐ No ☐ If yes, describe:_____

Have you ever had gum treatment? Yes ☐ No ☐ If yes, when?_____

Do you now or have you ever had any pain/discomfort in your jaw joint? (TMJ) Yes ☐ No ☐

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

Is there anything you would like to change about your smile? Yes ☐ No ☐ If yes, explain:_____

Are you happy with the color of your teeth? Yes ☐ No ☐

Do your gums bleed? Yes ☐ No ☐

How many times do you: floss/week?_____ brush/day?_____

Are your teeth sensitive to heat, cold or anything else? Yes ☐ No ☐ If yes, explain:_____

Have you ever had any unfavorable dental experiences? Yes ☐ No ☐ If yes, explain:_____

Why did you leave your previous dentist?_____ When was your last dental visit?_____

How can we accommodate your better during your dental visit?_____

At Hess Dental Care we offer a variety of services to enhance and keep your smile beautiful. Please **circle** any services below you would like our friendly staff to discuss with you during your visit.

Tooth whitening	Crowns/Bridges	Veneers	Cosmetic Bonding	Implants
Smile Makeover	Partials/Dentures	Sealants	Nightguard	Sport Mouthguard

Medical History

Do you have a personal physician? Yes ☐ No ☐ Date of last visit: _____

Physician's Name:_____ Physician's Phone:_____

Your current physical health is: Good ☐ Fair ☐ Poor ☐

Are you currently under the care of a physician? Yes☐ No☐ If yes, please explain:_____

Do you use tobacco in any form? Yes ☐ No ☐

Are you taking any medications? Yes ☐ No ☐ If yes, please list (or attach a list): _____

_____

Have you had any metal rods, pins or joint placed/replaced? Yes ☐ No ☐

If yes, specify which area of your body and when it was placed: _____

Have you ever been advised to take antibiotics before dental treatment? Yes ☐ No ☐ If yes, explain:_____

Have you been hospitalized in the past year? Yes ☐ No ☐ If yes, please explain: _____

YES	NO	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Treatment
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Anxiety
☐	☐	Arthritis
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Autoimmune Disease
☐	☐	Blood Transfusion
☐	☐	Cancer
☐	☐	Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Congestive Heart Failure
☐	☐	Depression
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Treatment
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Frequent Headaches

YES	NO	Conditions
☐	☐	Glaucoma
☐	☐	HIV+ AIDS
☐	☐	Heart Attack
☐	☐	Heart Disease
☐	☐	Heart Murmur
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	Hepatitis C
☐	☐	Herpes
☐	☐	High Blood Pressure
☐	☐	Joint Replacement
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Osteoporosis
☐	☐	Pace Maker
☐	☐	Radiation Therapy
☐	☐	Seizures
☐	☐	Sexually Trans. Disease
☐	☐	Shingles
☐	☐	Sickle Cell Disease

YES	NO	Conditions
☐	☐	Sinus Problems
☐	☐	Sleep Apnea
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Other_____

YES	NO	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline
☐	☐	Other:_____

YES	NO	If Female, Please Answer
☐	☐	Are you taking Birth Control Pills
☐	☐	Are you pregnant? If so, # of weeks?_____
☐	☐	Are you nursing?

The information present on these pages is true to the best of my knowledge. The undersigned authorizes Hess Dental Care to take X-rays, 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 Hess Dental Care, SC 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 _____