Gregory J. Moegling, D.D.S.

General Dentistry

New Patient Welcome Packet

Welcome to the dental offices of Gregory J. Moegling, D.D.S.

My staff and I are pleased to welcome you to our office. We are all equally committed to making sure that you receive the best dental care possible. We are happy to answer any questions that you may have. We work hard to make sure that we earn your trust and confidence.

Please take the time to complete the attached medical/dental history and general information forms before you come into the office. This will save both your time and ours and keep us on schedule for appointments during the day you visit. It is a relatively simple form to fill out but helps us in providing you with the proper care you need.

- ☐ Medical/Dental History Form
- ☐ General/Insurance Information form

We want you to feel relaxed and comfortable, so please let us know any special circumstances that we should be aware of during your first visit. Our main concern is to help you achieve an attractive, healthy smile.

Sincerely,

Gregory J. Moegling, D.D.S.

Gregory J. Moegling, D.D.S.

General Dentistry

Patient Information

☐ New Patient

We are committed to excellence in dentistry and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us - we will be happy to help.

Whom may we thank for referring you? _____

About You

Name: _____ I prefer to be called_____ [ ] Male [ ] Female

[ ] Single [ ] Married [ ] Child [ ] Other Birth date: ___/___/___ Age: _____ S.S. #: _____

Home Address: _____ City_____State____Zip_____

Home Phone: (____) _____ Work: (____) _____ ext. ___ Pager: (____) _____

Cell: (____) _____ E-mail Address: _____

Employer: _____ How long there? _____ Occupation: _____

Employer's Address: _____ City_____ State_____ Zip_____

Person Responsible For Account

[ ] Same as above Name: _____ Birth date:___/___/___ Relation: _____

Billing Address: _____ City_____State____Zip_____

Home Phone: (____) _____ Work: (____) _____ S.S. #: _____

Employer: _____ How long there? _____ Occupation:_____

Spouse Information

[ ] Same as above Name: _____ Birth date: ___/___/___

Employer: _____ Work Phone: (____) _____ ext. _____

Dental Insurance Information

Primary Insurance

Insurance Co. Name: _____ Phone: (____) _____ Group/Policy #: _____

Insured's Name: _____ Insured's Birth date: ___/___/___ Relation: _____

Insured's Social Security #: _____ Insured's Employer: _____

Secondary Insurance

Insurance Co. Name: _____ Phone: (____) _____ Group/Policy #: _____

Insured's Name: _____ Insured's Birth date: ___/___/___ Relation: _____

Insured's Social Security #: _____ Insured's Employer: _____

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Patient Information

☐ New Patient

Patient Name: _____ Date: _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____ E-Mail: _____

Phone (Home): _____ Mobil/Cell: _____ (Work): _____ Ext: _____

In case of Emergency, contact: Name _____ Phone _____ Relation _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Previous Dentist: _____

Date of Last Dental Visit: _____ Date of Last x-rays: _____

Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chest Pain
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Attack
- ☐ Heart Defect
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Jaundice
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse (MVP)
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy Due: _____
- ☐ Prescribed Weight Loss Med
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tobacco Usage
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Antibiotics Allergy
- ☐ Codeine Allergy
- ☐ Latex Allergy
- ☐ Penicillin Allergy
- ☐ Other Anesthetic Allergy

OTHER:

- ☐ _____
- ☐ _____
- ☐ _____

Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain: _____

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

Name of Physician: _____ Phone: _____

Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain: _____

Are you taking any medications? Please List: _____

Do you pre-medicate for dental appointments? ☐ Yes ☐ No If so, why _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

SIGNATURE: _____ Date:

Medical/Dental Health History

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