MILITARY SERVICE VERIFICATION FORM -

VERIFICATION OF ELIGABLILTY FOR DENTAL SERVICE DAY

Use of this form is required by Gremban & Gremban Dental for any applicant desiring services as a part of our ***free*** Veterans Dental Service Day.

To apply for an appointment, this form must be completed. To protect the confidentiality of the military and medical records of veterans, please have Vilas County Veterans Service Officer, Michael Biszak, complete the affidavit below certifying that the applicant is eligible for services.

The Vilas County Veterans Service Officer will need to see:

- Copy of DD-214 or Separation Papers
- Photo ID

APPLICANT INFORMATION

Name (Last, First, Middle Initial)	(Area Code) Telephone Number
Address, City, State, ZIP Code	Date of Birth (m/d/yyyy)
X	
(Signature of Applicant)	(Signature Date- m/d/yyyy)

ELIGIBILITY CERTIFICATION- To be completed by the Vilas County Veterans Service Officer

I, as a county veteran service officer, certify that I have reviewed the applicant's DD214 and have verified the applicant listed above qualifies as a veteran under the eligibility criteria within Wisconsin Statute, Section 45.01 (12)(a-f).	
X	
(Signature of County Veteran Service Officer)	**(Signature Date- m/d/yyyy)**

Patient s Name: _____

DENTAL HISTORY

Date: _____

What is the reason for your visit today? _____

_____

Date of Last Dental Visit: _____ **Last Cleaning:** _____

Were Any X-Rays taken? **YES** **NO**

Previous Dentist: _____ Phone: (_____) _____

_____

(Street) (City) (State) (Zip)

Do you have any dental problems now? **YES** **NO**

If YES, please describe: _____

Are your teeth sensitive:

Hot / Cold	**YES**	**NO**
Sweets	**YES**	**NO**

Have you ever had:

Orthodontic treatment	**YES**	**NO**
Oral surgery	**YES**	**NO**
Periodontal treatment	**YES**	**NO**
Your teeth ground or bite adjusted	**YES**	**NO**
A mouth guard	**YES**	**NO**
A serious injury to the mouth / head	**YES**	**NO**

Have you experienced:

Clicking or popping of the jaw	**YES**	**NO**
Pain (joint, ear, side of face)	**YES**	**NO**
Difficulty in opening or closing mouth	**YES**	**NO**
Difficulty in chewing on either side of mouth	**YES**	**NO**
Headaches, neckaches or shoulder aches	**YES**	**NO**

Are you satisfied with your teeth's appearance?	**YES**	**NO**
Do you feel nervous about having dental treatment?	**YES**	**NO**
If YES, what is your biggest concern?	**YES**	**NO**
Is there anything else about having dental treatment that you would like us to know?	**YES**	**NO**

If YES, please describe: _____

I UNDERSTAND THAT ALL THE INFORMATION THAT I HAVE GIVEN IS NECESSARY TO PROVIDE ME WITH DENTAL CARE IN A SAFE AND EFFICIENT MANNER. I HAVE ANSWERED ALL QUESTIONS TO THE BEST OF MY KNOWLEDGE. SHOULD FURTHER INFORMATION BE NEEDED, YOU HAVE MY PERMISSION TO ASK THE RESPECTIVE HEALTH CARE PROVIDER, WHO MAY RELEASE SUCH INFORMATION TO YOU. I WILL NOTIFY THE DOCTOR OF ANY CHANGE IN MY HEALTH OR MEDICATION.

Patient/Guardian Signature: _____ **Date:** _____

HISTORY REVIEW

Assistant Signature: _____ **Date:** _____

Doctor Signature: _____ **Date:** _____

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HEALTH / DENTAL HISTORY

We are a health-centered dental practice, thus we are concerned with your total well-being, not just your oral health. Please fill out the health questionnaire below completely – even if some of the questions may not seem relevant to you dental health. **All information is completely confidential.** (Circle YES or NO)

1. Have you been under the care of a physician during the past two years? ..... **YES** **NO**

   If yes, for what? _____

   Physician's Name: _____ Phone: (_____) _____

   Address: _____
   (Street) (City) (State) (Zip)

2. Are you taking medication, drugs or pills now? ..... **YES** **NO**

   If YES, please list name / dosage _____

3. Have you ever taken Fen-Phen or other dietary aids? ..... **YES** **NO**

4. Have you been hospitalized in the last 5 years? ..... **YES** **NO**

5. Are you aware of having an allergic **(or adverse reaction)** to any medication? ..... **YES** **NO**

   If YES, please list _____

6. Have you had unfavorable reactions to any of the following? (Please circle)

   ASPIRIN CODEINE LOCAL ANESTHETICS SEDATIVES SULFA PENICILLIN

   LATEX FOOD ALLERGIES FOOD DYES

7. Were you ever required to take an antibiotic premedication for dental treatment due to any of the following medical conditions? (Please circle)

   HEART MURMUR ARTIFICIAL HEART VALVE MITRAL VALVE PROLAPSE

   PNEUMATIC FEVER ARTIFICIAL JOINT (hip, knee, etc.)

8. Indicate which of the following you have had, or have at present. (Circle YES or NO)

Organ Transplant	**YES**	**NO**	Chronic Cough	**YES**	**NO**
Heart (Surgery, Disease, Attack)	**YES**	**NO**	Tuberculosis	**YES**	**NO**
Chest Pain	**YES**	**NO**	Asthma	**YES**	**NO**
Congenital Heart Disease	**YES**	**NO**	Allergies	**YES**	**NO**
Heart Murmur	**YES**	**NO**	Radiation Treatments	**YES**	**NO**
High Blood Pressure	**YES**	**NO**	Malignancies / Cancer	**YES**	**NO**
Artificial Heart Valve	**YES**	**NO**	Hepatitis A (infectious)	**YES**	**NO**
Heart Pacemaker	**YES**	**NO**	Hepatitis B (serum)	**YES**	**NO**
Rheumatic Fever	**YES**	**NO**	Non-A Non-B Hepatitis	**YES**	**NO**
Arthritis / Rheumatism	**YES**	**NO**	A.I.D.S.	**YES**	**NO**
Stroke / Use of Blood Thinners	**YES**	**NO**	HIV Positive	**YES**	**NO**
Artificial Joint (Hip, Knee, etc.)	**YES**	**NO**	Canker / Cold Sores / Fever Blisters	**YES**	**NO**
Kidney Trouble	**YES**	**NO**	Blood Transfusions	**YES**	**NO**
Ulcers	**YES**	**NO**	Anemia	**YES**	**NO**
Diabetes	**YES**	**NO**	Epilepsy / Seizures	**YES**	**NO**
Thyroid Problems	**YES**	**NO**	Fainting / Blackouts	**YES**	**NO**
Glaucoma	**YES**	**NO**	Nervous Disorders	**YES**	**NO**
Emphysema	**YES**	**NO**	Psychiatric / Psychological Care	**YES**	**NO**
Female: Are you pregnant and/or nursing? ...	**YES**	**NO**			

(Continued on back)

Patient Information

Mr Mrs Miss Ms (Circle One) Male Female

(Last Name) (First Name) (Middle Initial)

Preferred Name:_____ Birth Date: _____ Social Security #_____

Occupation: _____ Employer: _____ Work Phone:_____

Home Address: _____

(Street) (City) (State) (Zip)

Billing Address: _____

(Street or PO Box) (City) (State) (Zip)

Home Phone:_____ Cell Phone:_____ E-Mail: _____

Spouse's Name:_____ Birth Date:_____ Social Security #_____

Employer:_____ Work Phone:_____ Cell Phone:_____

Person to Contact in Case of Emergency:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Who Referred You to Our Office? _____ If Not Referred How Did You Find Us?_____

If this Appointment Is For Your Child - Who Does Child Live With: (Circle One) Father Mother Both Parents

School That He/She Attends: _____

Father's Name: _____ Mother's Name:_____

Father's Employer: _____ Mother's Employer: _____

Father's Work Phone:_____ Mother's Work Phone: _____

Dental Insurance, Please Provide Your Insurance Card

I hereby authorize the release of any information including the diagnosis and the records of any treatments or examinations rendered, to my insurance company or companies. This release is solely for the purpose of facilitating the billing and reimbursement, directly to the dentist, of insurance benefits under which I am entitled.

I agree to be responsible for payments of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

Responsible Party:_____ Relationship to Patient:_____ Date:_____