Earl E. Woeltje DDS MAGD
712 N. Bloomington St.
Streator, Illinois 61364
815-672-2195

WE WOULD LIKE TO GET TO KNOW YOU BETTER!

There are three pages please answer them to the best of your knowledge.

Name________________________________Address________________________

City______________________ State_______________ Zip Code___________

Home Phone_______________ Cell Phone_______________ Sex____________

Email (For our office only) ____

Birth Date_______________ Social Security Number___________________

MARITAL (S,M,W,D)___________ Spouse's Name_________________________

Patient's Employer______________________Occupation_________________

Employer's Address____

Work Phone Number__________________________Extension_______________

Whom May We Thank For Referring You to Our Office?
____

Who will be responsible for payment of this account.
____

If different than above:

Address____

City_________________________________State__________Zip____________

Employer_____________________Social Security Number________________

Employer's Address____

Work Phone Number____________________________Extension_____________

Relationship to Patient: Parent_________Spouse_________Other_______

If you also have dental insurance please ask for our Insurance Policy so we can enter your information accurately

MEDICAL HISTORY

1. Who is your physician: ____________________________________
2. Please list: all medications you are presently taking (i.e. Birth control, aspirin):
   ____
   ____
3. Please list all medications you are allergic or had an Adverse reaction to: ______________________________________
   ____
4. Have you ever had major surgeries? ....Yes No
   Operations and dates____
   ____
5. Do you have any heart problems such as but not limited to the following (please circle): ....Yes No
   - Mitral Valve Prolapse
   - Heart Attack
   - Stroke
   - Heart Murmur
   - Valve replacement
   - Rheumatic Fever
   - Other
6. Have you ever had breathing difficulty such as asthma, emphysema, pneumonia, tuberculosis? ....Yes No
7. Do you have a history of excessive bleeding ....Yes No
8. Do you have high blood pressure ....Yes No
9. Are you currently taking aspirin?....................Yes No
   Do you regularly take aspirin?...................Yes No
10. Are you subject to fainting, dizziness, nervous disorders, convulsions, or epilepsy?................Yes No
11. Are there any limitations to your physical activity ....Yes No
12. Do you use tobacco products? ....Yes No
    What Kind____________ How Much_____________
13. Do you have sinus troubles ....Yes No
14. Are you or could you be pregnant? ....Yes No
15. Have you ever tested HIV positive ....Yes No
16. Circle any of the conditions below that you may have or have had in the past:
    - Anemia
    - Hepatitis
    - Diabetes
    - Jaundice
    - Glaucoma
    - Kidney Disease
    - Arthritis
17. My Height___________________ My Weight _____________________

I understand that the information I provide on this form is essential to determine my overall health needs. I have read and understand each question; I have answered all of them truthfully and to the best of my knowledge.

Signature ______________________________________Date____________
Patient, Parent, or Guardian

With my dentures, I can chew...

0-25-50-75-100%
Nothing Anything I Want

When I wear my dentures, I experience pain...

0-25-50-75-100%
Never All the time

I am satisfied with the esthetic of my dentures...

0-25-50-75-100%
Not at all Extremely

If not the front teeth are...

too light ...too dark
too long ...too short
too big ...too small
too far forward ...too far backward

The pink is...
too light ...too dark

I want a ...smile (please pick one it is just a start)

natural
perfect like entertainers
exactly the same as I have now
I do not care

I expect to be satisfied with the esthetic of my NEW dentures

0-25-50-75-100%
Not at all Extremely

With my NEW dentures, I expect to chew...

0-25-50-75-100%
Nothing Anything I Want