David J. Aicher DDS
617 Jackson Street
Wausau, WI 54403
(715) 845-5459

A MEMBER OF THE
CHERRY TREE DENTAL
NETWORK

Welcome to our practice! To help us better serve you, please complete the following information:

Patient Information

Date_______________ Home Phone (_____) ___________________ Cell Phone (_____) _____________________

Name ____ SS/HIC/Patient ID#______________________

Last Name First Name (Preferred Name) MI

Address____ E-mail ________________________________

City ____ State_______ Zip____________________

Sex ☐ Male ☐ Female Age ________ Birthdates __________ Employer/School Phone (____) ____________

Patient Employer/School ____________________________________ Occupation ____________________________

Employer/School Address____

Whom may we thank for referring you? ____

In case of emergency, who should be notified? ______________________________ Phone (_____) _______________

Primary Insurance

Person Responsible for Account ____

Last Name First Name Middle Initial

Relation to Patient_____________________________ Birthdate_________________ Soc. Sec. #________________

Address (if different from patient's)____ Phone (_____) _____________

City ____ State_______ Zip____________________

Person Responsible Employed by ____ Occupation _______________

Business Address ____ Business Phone (____) _____________

Insurance Company ____

Contract # __________________________ Group # ____________________________ Subscriber # _______________

Names of other dependents covered under this plan ____

* Please see our front desk if you have additional or supplemental insurance plans.

Authorization

I certify that I, and/or my dependent(s), have insurance coverage with the Insurance Company(ies) named above on this form and assign directly to Cherry Tree Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance.

I understand the dentists of Cherry Tree Dental may use my health care information and may disclose such information to the above named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

If I have dental insurance, this office will file my insurance claim for me. An initial pre-treatment estimate of costs may be submitted by the office to my insurance carrier, as required by all insurance carriers, after my examination and before treatment starts. The office may require pre-payment of all or a portion of anticipated charges prior to the start of my service.

My account balance will be given 60 days of free handling, usually to await insurance handling. FULL PAYMENT OF THE ENTIRE BALANCE IS EXPECTED 60 DAYS FROM DATE OF TREATMENT. After 60 days a 1½% a month handling charge will be applied to all unpaid balances. The office offers a number of financial payment options for your convenience. I can obtain more information about these alternatives from the office's front desk.

By signing below I certify that I have read and understand the above information to the best of my knowledge, that the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient Name (Print) ______________________________________

Patient (Parent's) Signature ______________________________________ Date____________

Office Initials ____________

Health History

Physician's Name ____ Date of Last Visit ____________________

Have you ever taken "fen-phen?" (phentermine), Ionimin, Apidex, Fastin, Pondimin (fenfluramine) or Redux (dexfenfluramine)? ☐ Yes ☐ No

Have you ever had bisphosphonate drugs for Cancer or Osteoporosis (such as Phosamax, Actonel, Boniva, Aredia, Zometa, Didroel)? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No If Yes, how often? ____________________

Have you had any serious illnesses or operations? ☐ Yes ☐ No If Yes, describe____________________________

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Please circle if you have had any of the following:

Alzheimer's Disease	Cold sores/Herpes	Heart Murmur	Mitral Valve Prolapse
Anemia	Cortisone Treatments	Heart Problems	Pacemaker
Arthritis, Rheumatism	Cough, Persistent	Heart Procedures in last 3 months	Respiratory Disease
Artificial Heart Valves	Cough up Blood	Hemophilia	Rheumatic Fever
Artificial Joints, Hips, etc.	Diabetes	Hepatitis	Scarlet Fever
Asthma	Dialysis	High Blood Pressure	Shortness of Breath
Auto Immune Disease, such as Lupus	Dry Mouth	HIV/AIDS	Skin Rash
Back Problems	Eating Disorders (Anorexia, Bulimia)	Jaw Pain	Stroke
Blood Disease	Epilepsy/Seizures	Kidney Disease	Swelling of Feet, Ankles
Cancer	Fainting	Liver Disease	Thyroid Problems
Chemical Dependency	GERD	Malignant Hypothermia	Tonsillitis
Chemotherapy/Radiation	Glaucoma	Mental Health Care, Diagnosis__________	Transplants
Circulatory problems	Headaches		Tuberculosis
			Ulcer

MEDICATIONS (List Medications you are currently taking)	ALLERGIES

Dental History

Reason for today's visit____ Date of last dental care ______________

Former Dentist__________________________ City, State________________ Date of last X-rays ________________

Are you satisfied with your past dentistry? ___ If no, please tell us why? ______________________________

Please circle if you've had problems with any of the following:

Bad breath	Food collection between teeth	Jaw pain	Sensitivity to hot
Bleeding gums	Grinding teeth, clenching (day, night)	Loose teeth or broken fillings	Sensitivity to sweets
Clicking or popping jaw	Headaches	Periodontal treatment	Sensitivity when biting
		Sensitivity to cold	Sores or growths in mouth

How often do you floss? _________________________ How often do you brush? ____________________________

Have you ever been treated for a bad bite, orthodontics or splint therapy? _______ When? ____________________

Please describe your soda consumption ____

Have you noticed darkening of tooth structure due to nerve removal/root canal treatment? ___________________

Is there anything about your teeth or smile that you would like to change? _____________________________

Are you anxious about dental appointments? ____