Wenhui Sun, DMD
617 Jackson Street
Wausau, WI 54403
(715) 842-3321

Advanced Dental Professionals

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 ________ Birthdate ___________ 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
Anemia
Arthritis, Rheumatism
Artificial Heart Valves
Artificial Joints, Hips, etc.
Asthma
Auto Immune Disease, such as Lupus
Back Problems
Blood Disease
Cancer
Chemical Dependency
Chemotherapy/Radiation
Circulatory problems
Cold sores/Herpes
Cortisone Treatments
Cough, Persistent
Cough up Blood
Diabetes
Dialysis
Dry Mouth
Eating Disorders (Anorexia, Bulimia)
Epilepsy/Seizures
Fainting
GERD
Glaucoma
Headaches
Heart Murmur
Heart Problems
Heart Procedures in last 3 months
Hemophilia
Hepatitis
High Blood Pressure
HIV/AIDS
Jaw Pain
Kidney Disease
Liver Disease
Malignant Hypothermia
Mental Health Care, Diagnosis_________
Mitral Valve Prolapse
Pacemaker
Respiratory Disease
Rheumatic Fever
Scarlet Fever
Shortness of Breath
Skin Rash
Stroke
Swelling of Feet, Ankles
Thyroid Problems
Tonsillitis
Transplants
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
Bleeding gums
Clicking or popping jaw
Food collection between teeth
Grinding teeth, clenching (day, night)
Headaches
Jaw pain
Loose teeth or broken fillings
Periodontal treatment
Sensitivity to cold
Sensitivity to hot
Sensitivity to sweets
Sensitivity when biting
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? ____