- Charles A. Sowieja, D.D.S., S.C. –

PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient's Name _____ Preferred Name _____
(First, M.I., Last)

Date of Birth _____ Male / Female ❑Minor ❑Single ❑Married ❑Divorced ❑Widowed ❑Separated ❑Other

Address_____ City_____ State____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____ Ext_____

Please circle your preferred contact # above. Email_____

How do you prefer to be contacted to confirm appointments? ❑ Phone Call ❑ Text ❑ Email

If text, please provide your cell phone carrier (ATT, Cellcom, Verizon, etc.) _____

How did you hear about our office? _____

EMERGENCY Contact Name _____ Relationship_____ Phone _____

RESPONSIBLE PARTY *(If other than Patient)*

Name of Person Responsible for Account _____ Relationship to Patient _____

Address (if different than Patient)_____ City_____ State____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____ Ext_____

DENTAL INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE

Insured's Name / Relationship to Patient _____ Date of Birth_____

Insured's Employer _____ Insurance Company _____

Group # _____ ID# or Social Security # of Subscriber _____

Insurance Co. Address _____

Insurance Co. Phone Number _____

SECONDARY DENTAL INSURANCE

Insured's Name / Relationship to Patient _____ Date of Birth_____

Insured's Employer _____ Insurance Company _____

Group # _____ ID# or Social Security # of Subscriber _____

Insurance Co. Address _____

Insurance Co. Phone Number _____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Heart Pacemaker
- ❑ Congenital heart problems
- ❑ Artificial heart valve
- ❑ Artificial joint
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Stroke
- ❑ Lung or breathing problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Blood transfusion
- ❑ Diabetes (insulin/diet controlled)
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Arthritis/Rheumatism
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma
- ❑ Multiple Sclerosis
- ❑ Neuro-muscular disease
- ❑ Liver diseases
- ❑ Hepatitis or jaundice
- ❑ Kidney disease
- ❑ Thyroid or parathyroid problems
- ❑ Ulcers
- ❑ Digestive disorders/acid reflux
- ❑ Glaucoma
- ❑ Head/neck injuries
- ❑ Sexually transmitted disease
- ❑ Chemotherapy
- ❑ Radiation Therapy
- ❑ Emotional problems
- ❑ Psychiatric treatment
- ❑ Alcohol/drug dependency
- ❑ Sleep Apnea
- ❑ Osteoporosis or bone disorders
- ❑ Hearing problems

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Tetracycline
- ❑ Aspirin or Ibuprofen
- ❑ Other:_____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Other:_____

Women:

- ❑ May be pregnant
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives

Name of your physician:_____

Do you have any disease, condition, or problem not listed above?_____

Please add anything else you would like us to know about:_____

_____

Have you been hospitalized in the last 5 years for any reason? Please explain _____

_____

Authorization and Release:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

I also authorize the Dentist to release any information including the diagnosis and the records of treatment or examination rendered during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the Dentist or Dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient (or parent/guardian if minor) Date

PATIENT NAME _____ DATE OF BIRTH _____

DENTAL HEALTH HISTORY

***Circle** any of the following conditions which you have now or may have had in the past:*

Bleeding Gums
Swelling or Lumps in Mouth
Clenching or Grinding Teeth
Blister/Sores on Lips or Mouth
Oral Habits, e.g. fingernail biting
Unfavorable Dental Experience
Extensive Crown and Bridge-work

Bad Breath
Periodontal Treatment
Orthodontic Treatment
Mouth Breathing
Complications from Oral Surgery
Pain or Unusual sounds in Jaw, Joints, or Ear

***Circle** any of the following that you use:*

Cigarettes, pipe, cigars_____ per day
Chewing Tobacco
Pop and/or Juice Intake_____ per day

Dental Floss____ x/week
Water Jet Device
Fluoride Supplement or Rinse
Brush your teeth____ x/day

Do you prefer anesthetics? ❑ yes ❑ no Do you prefer Nitrous Oxide (laughing gas)? ❑ yes ❑ no

At present, do you have any dental concerns? _____

_____

Have you experienced trauma to the jaw? ❑ yes ❑ no If yes, explain _____

_____

Have you had orthodontic treatment (braces)? ❑ yes ❑ no

How long do you expect to keep your teeth?_____

What prompted you to seek dental care at this time? _____

Is there anything in your past dental history I should know about? ❑ yes ❑ no If yes, explain _____

_____

Are you satisfied with your past dental care? ❑ yes ❑ no If not, explain _____

_____

Date of last cleaning: _____ Date of last dental x-rays: _____

Do you like the way your teeth look? ❑ yes ❑ no If not, what would you like to change if you could? _____

_____