- 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 _____

CHILD MEDICAL AND DENTAL HEALTH HISTORY

Your child's overall health as well as any medications which your child takes could have an important inter-relationship with the dental care your child receives. Please answer each of the following questions completely.

Previous Dentist _____ Date of Last Dental Visit _____

How often does your child brush? _____ How often does your child floss? _____

Is your child's water fluoridated? ❑ yes ❑ no Does your child take fluoride supplements? _____

Has your child had difficulties with past dental visits? ❑ yes ❑ no … If yes, please explain_____

_____

Does your child:

Suck thumb/finger……....❑ yes ❑ no
Suck/Bite Lip……❑ yes ❑ no
Bite/Chew Nails……...….❑ yes ❑ no
Chew hard objects (pencils, etc.)……... ❑ yes ❑ no
Grind Teeth……❑ yes ❑ no
Clench Jaws……❑ yes ❑ no

Child's Physician and Location _____

Please list any Hospitalizations, Surgeries, Serious Illnesses: When?

_____ _____

_____ _____

Is your child currently taking any medications? ❑ yes ❑ no (If yes, please list) _____

_____

Has your child ever taken Fen-Phen/Redux? ❑ yes ❑ no

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (penicillin, Novocain, etc)? ❑ yes ❑ no (If yes, please list) _____

Does your child have a history of allergies to any other substances (latex, environmental, etc.)? ❑ yes ❑ no
(If yes, please list) _____

Has your child ever had any of the following:

Asthma……..❑ yes ❑ no
Cancer……...❑ yes ❑ no
Hepatitis……❑ yes ❑ no
HIV/AIDS……...…..❑ yes ❑ no
Hemophilia……,…..❑ yes ❑ no
Persistent cough or throat clearing
not associated with a known illness
(lasting more than 3 weeks) …….❑ yes ❑ no
Abnormal Bleeding……...❑ yes ❑ no
Stomach, liver or kidney problems……..❑ yes ❑ no
Handicaps/Disabilities……❑ yes ❑ no
Tuberculosis……...❑ yes ❑ no
Diabetes……..….❑ yes ❑ no
Rheumatic Fever……❑ yes ❑ no
Congenital Heart Defect……..….❑ yes ❑ no
Heart Murmur……..❑ yes ❑ no
Convulsions/Epilepsy……..….❑ yes ❑ no

Please explain any medical problems that your child has: _____

_____

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 child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

I also authorize the Dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child 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.

_____ _____ _____

Printed Name of Patient Signature of Parent or Guardian Date