Welcome!

Thank you for selecting our dental healthcare team! Our commitment is to provide you with the highest quality of oral health care in the most gentle manner possible. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us ~ we will be happy to help.

Patient Information

Date _____

Name _____ Birthdate _____

Address _____ Soc. Sec. # _____

_____ Home Phone _____

E-mail _____ Cell Phone _____

If minor - person responsible / relationship _____

Person to Contact in Case of Emergency _____ Phone _____

Who may we thank for referring you? _____

Insurance Information: (Copy of card needed)

Company Name _____ Employer _____

Subscriber Name _____ Subscriber Date of Birth _____

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	YES	NO
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐

_____

_____

4. Are you allergic or have had any reactions to the following?

	YES	NO		YES	NO		YES	NO
a) Local anesthetics (novocaine)	☐	☐	c) Sulfa drugs	☐	☐	e) Rubber or Latex	☐	☐
b) Penicillin or other antibiotics	☐	☐	d) Metals or jewelry	☐	☐	f) Other	☐	☐

5. Do you smoke / chew tobacco?	☐	☐
6. Have you used narcotics, cocaine or other drugs?	☐	☐
7. Do you or has anyone told you that you snore?	☐	☐

8. Do you have or have you had any of the following?

	YES	NO		YES	NO		YES	NO
Heart Disease	☐	☐	Hay Fever/Allergies	☐	☐	Epilepsy	☐	☐
Heart Attack	☐	☐	AIDS or HIV Infection	☐	☐	Kidney Diseases	☐	☐
Artificial Heart Valve	☐	☐	Sexually Transmitted Disease	☐	☐	Thyroid Problems	☐	☐
Cardiac Pacemaker	☐	☐	Cancer	☐	☐	Anemia	☐	☐
Heart Murmur	☐	☐	Leukemia	☐	☐	Liver Disease	☐	☐
Mitro Valve Prolasp	☐	☐	Tuberculosis	☐	☐	Joint Replacement or Implant	☐	☐
High Blood Pressure	☐	☐	Glaucoma	☐	☐	Stomach Troubles/Ulcers	☐	☐
Low Blood Pressure	☐	☐	Arthritis	☐	☐	Epilepsy/Convulsions	☐	☐
Respiratory Problems	☐	☐	Diabetes	☐	☐	Fainting/Seizures	☐	☐
Asthma	☐	☐	Stroke	☐	☐	Multiple Sclerosis	☐	☐
Emphysema	☐	☐	Rheumatic Fever	☐	☐			

9. Women Only:	a) Are you pregnant or think you may be pregnant?	☐	☐
	b) Are you nursing?	☐	☐
	c) Are you taking birth control pills?	☐	☐

Patient Dental History

1. How long since your last dental visit? _____

   Previous Dentist _____

2. What was done at that visit? _____

3. Purpose of this visit? _____

	YES	NO
4. Do your gums bleed or hurt?	❑	❑
5. Are your teeth sensitive to: Hot?	❑	❑
Cold?	❑	❑
Sweets?	❑	❑
Biting Pressure?	❑	❑
6. Do you feel pain to any of your teeth?	❑	❑
7. Do you have any sores or lumps in or near your mouth?	❑	❑
8. Have you had any head, neck or jaw injuries?	❑	❑
9. Have you ever experienced any of the following problems in your jaw:		
a) Clicking or popping?	❑	❑
b) Pain (joint, ear, side of face)?	❑	❑
c) Difficulty in opening / closing?	❑	❑
d) Difficulty in chewing?	❑	❑
10. Do you have frequent headaches?	❑	❑
11. Do you clench or grind your teeth?	❑	❑
12. Does food get caught between your teeth?	❑	❑
13. Have you ever had any difficult extractions?	❑	❑
14. Have you ever had any prolonged bleeding following extractions?	❑	❑
15. Have you ever had any orthodontic (braces) work?	❑	❑
16. Have you ever had periodontal (gums) work?	❑	❑
17. Have you ever had instruction on the correct method of caring for your teeth and gums?	❑	❑

18. How often do you brush? _____

19. How often do you floss? _____

20. What other dental aids do you use? (proxybrush, toothpicks) _____

21. Please rate your teeth from one to ten. Ten being the best. _____

22. What did you like or dislike about your past dental experiences? _____

_____

23. What do you expect of us as your dental office? _____

_____

24. Why did you choose not to have dental work done in the past?: a) time b) cost c) pain d) fear _____

_____

Health Insurance portability and Accountability Act (HIPAA)

Authorization and Release

I certify that I have read and understand the above information and the above questions have been accurately answered. I authorize release of any medical information about me to my insurance carrier and third party payers. I request that payments be made to Dr. Tony Piantek, DDS for any services rendered.

Payment is expected at the time of service when there is no insurance coverage or for services not covered by insurance.

HIPAA policy is available upon request.

Signature _____ Date _____