(P L E A S E P R I N T)

Patient Information

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Dental Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist 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. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

Phone Numbers

Home (_____) _____ Work (_____) _____ Ext _____ Cell Phone (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

Dental History

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Foreign objects	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in your mouth	☐ Yes	☐ No

How often do you floss? _____

How often do you brush? _____

Dental Registration and History

MARK A. WOJCIECHOWSKI DDS, PC
Creating Beautiful Smiles
800 S. Milwaukee Ave., Suite 111, Libertyville, IL 60048 • (847) 362-5511 • wojdental.com

NAME_____BIRTHDATE_____

Parent or Guardian Name, if patient is a minor_____

HEALTH HISTORY (please check if you have had any of the following)

Yes	No	Chest pain, shortness of breath	Yes	No	Diabetes
Yes	No	Bleeding problems or blood thinning medications	Yes	No	Thyroid problems
Yes	No	Headaches	Yes	No	Tumors, cancer
Yes	No	Heart disease, heart murmur, rheumatic Fever, prosthetic heart valve, mitral valve Prolapse	Yes	No	Psychiatric/Neurological care
			Yes	No	Kidney or bladder disease
Yes	No	Pacemaker	Yes	No	Sexual transmitted disease
Yes	No	Heart attack	Yes	No	HIV positive, AIDS
Yes	No	Hepatitis A, B, C, or liver disease	Yes	No	Are you now pregnant?
Yes	No	TB, asthma or lung disease	Yes	No	Birth control pills
Yes	No	Do you smoke?	Yes	No	Stroke or TIA
Yes	No	High blood pressure, hypertension	Yes	No	Seizure disorders
Yes	No	Adverse reaction to local anesthetic			

Sleep Apnea Evaluation

Yes	No	Have you ever been diagnosed with Sleep Apnea?	Yes	No	Do you snore?
Yes	No	Have you ever had an overnight sleep study completed?	Yes	No	Do you currently use a CPAP sleep device
Yes	No	Do you wake up in the morning with headaches?			
Yes	No	Have you been told that you gasp for air or suddenly stop breathing while sleeping?			

Yes No Have you ever taken any of the following medications: Actonel, Fosamax, Boniva, or Zometa, or any other drug in the bisphosphonate class?

Are you allergic to, or do you suffer ill effects from any of the following:
Penicillin Aspirin Codeine

List any allergies:_____

List all medications:_____

_____

Dentist Signature:_____ Date:_____

Patient Signature:_____ Date:_____