PECHEK DENTAL & associates

PATIENT INFORMATION FORM

PATIENT NAME _____
LAST FIRST MIDDLE PREFERRED NAME

HOME ADDRESS _____
STREET CITY STATE ZIP

EMAIL _____ REFERRED BY _____

BIRTHDAY _____ SOCIAL SECURITY NO. ___ - ___ - ____ SEX M F

PREFERRED NO.

PLEASE CHECK ONE: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ OTHER

CELL PHONE _____ ☐
HOME PHONE _____ ☐
WORK PHONE _____ ☐

EMPLOYED BY _____

MAY WE TEXT YOUR CELL? ☐ YES ☐ NO

PRIMARY DENTAL INSURANCE COMPANY	SECONDARY DENTAL INSURANCE COMPANY
GROUP NAME	GROUP NAME
GROUP NO.	GROUP NO.
SUBSCRIBER NAME	SUBSCRIBER NAME
SUBSCRIBER ID	SUBSCRIBER ID
SUBSCRIBER DOB / /	SUBSCRIBER DOB / /
HOME PHONE (IF DIFFERENT)	HOME PHONE (IF DIFFERENT)
EMPLOYED BY	EMPLOYED BY
BUS. PHONE	BUS. PHONE
ADDRESS (IF DIFFERENT FROM PATIENT)	ADDRESS (IF DIFFERENT FROM PATIENT)

PERSON RESPONSIBLE FOR ACCOUNT BILLING: _____
LAST FIRST

STREET CITY STATE ZIP

EMERGENCY CONTACT: _____
NAME PHONE

DENTAL HISTORY

1	REASON FOR VISIT:_____		
2	DATE OF LAST DENTAL VISIT:		
3	WOULD YOU LIKE NITROUS OXIDE FOR DENTAL TREATMENT? (ADDITIONAL CHARGE)	☐ YES	☐ NO
4	HAVE YOU BEEN DIAGNOSED WITH PERIODONTAL (GUM) DISEASE?	☐ YES	☐ NO
5	DO YOUR GUMS BLEED DURING BRUSHING/FLOSSING?	☐ YES	☐ NO
6	ARE YOU HAPPY WITH THE APPEARANCE OF YOUR TEETH?	☐ YES	☐ NO
7	ARE YOUR TEETH SENSITIVE TO HOT, COLD , SWEETS, OR PRESSURE? (PLEASE CIRCLE)	☐ YES	☐ NO
8	ARE YOU AWARE OF GRINDING OR CLENCHING YOUR TEETH?	☐ YES	☐ NO
9	ARE YOUR JAWS OR TEETH SORE WHEN YOU AWAKE FROM SLEEP?	☐ YES	☐ NO
10	DO YOU HAVE HEADACHES, EARACHES, OR NECK PAINS? (PLEASE CIRCLE)	☐ YES	☐ NO
11	DO YOU HAVE ANY CLICKING, POPPING, OR DISCOMFORT IN THE JAW? (PLEASE CIRCLE)	☐ YES	☐ NO
12	HAVE YOU EVER WORN BRACES ON YOUR TEETH?	☐ YES	☐ NO
13	HAVE YOU EXPERIENCED ANY PROBLEMS WITH ANESTHESIA?	☐ YES	☐ NO

PATIENT NAME: DATE:

PLEASE ALL LIST MEDICATIONS, INCLUDING SUPPLEMENTS, YOU ARE CURRENTLY TAKING. INCLUDE DOSAGE.

MEDICAL HISTORY

1	DO YOU HAVE ANY CURRENT HEALTH ISSUES? PLEASE EXPLAIN.	☐ YES	☐ NO
2	DATE OF LAST PHYSICAL EXAMINATION: _____ PHYSICIAN NAME: PHONE:		
3	HAVE YOU HAD A SERIOUS ILLNESS, OPERATION, OR BEEN HOSPITALIZED IN PAST 5 YEARS? IF YES, WHAT WAS THE ILLNESS OR PROBLEM?	☐ YES	☐ NO
4	HAVE YOU EVER HAD SURGERY, RADIATION THERAPY, OR CHEMOTHERAPY FOR TUMORS OR OTHER CONDITION? PLEASE EXPLAIN.	☐ YES	☐ NO
5	ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO ANTIBIOTICS, METALS, JEWELRY, OR OTHER MEDICATIONS? PLEASE CIRCLE AND SPECIFY TYPE OF REACTION.	☐ YES	☐ NO
6	HAVE YOU TAKEN, ARE YOU TAKING, OR ARE YOU SCHEDULED TO BEGIN TAKING: ORAL BISPHOSPHONATES: ALENDRONATE (FOSAMAX), IBANDRONATE (BONIVA), OR RISEDRONATE (ACTONEL) OR INTRAVENOUS BISPHOSPHONATE: PAMIDRONATE (AREDIA) OR ZOLEDRONIC ACID (ZOMETA) IF YES, WHAT DRUG, DOSE, FREQUENCY, AND DURATION?	☐ YES	☐ NO
7	DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES, PROBLEMS, OR SYMPTOMS? IF YES, PLEASE EXPLAIN.		
	CARDIOVASCULAR/HEART PROBLEM	☐ YES	☐ NO
	NEUROLOGIC PROBLEM	☐ YES	☐ NO
	ABNORMAL BLEEDING OR CLOTTING	☐ YES	☐ NO
	BLOOD/HEMATOLOGIC DISORDER	☐ YES	☐ NO
	KIDNEY/LIVER DISORDER	☐ YES	☐ NO
	IMMUNOSUPPRESSION	☐ YES	☐ NO
	DIABETES	☐ YES	☐ NO
	ASTHMA, SLEEP APNEA OR RESPIRATORY PROBLEM	☐ YES	☐ NO
8	HAVE YOU TESTED POSITIVE FOR HIV/AIDS, HEPATITIS OR ANY OTHER INFECTIOUS DISEASE?	☐ YES	☐ NO
9	ANY CONDITIONS OR INFECTIONS WE SHOULD BE AWARE OF?	☐ YES	☐ NO
10	DO YOU CURRENTLY OR HAVE YOU EVER USED TOBACCO PRODUCTS? IF YES, WHAT TYPE, AMOUNT, AND DURATION?	☐ YES	☐ NO
11	DO YOU CURRENTLY OR HAVE YOU EVER USED ILLEGAL OR ILLICIT DRUGS? IF YES, WHAT TYPE, AMOUNT, AND DURATION?	☐ YES	☐ NO
12	IF FEMALE, ARE YOU PREGNANT? IF SO, NUMBER OF WEEKS?	☐ YES	☐ NO
13	IF FEMALE, ARE YOU NURSING?	☐ YES	☐ NO

CHILDREN ONLY

1	IS THIS THE CHILD'S FIRST VISIT TO THE DENTIST?	☐ YES	☐ NO
2	DOES THE CHILD SUCK THE THUMB, FINGERS, OR PACIFIER? (please circle)	☐ YES	☐ NO
3	IS THE CHILD EXTREMELY NERVOUS ABOUT DENTISTRY?	☐ YES	☐ NO
4	HAS THE CHILD HAD ANY DIFFICULT VISITS TO THE PHYSICIAN OR HOSPITAL?	☐ YES	☐ NO

I CERTIFY THAT THE INFORMATION PROVIDED ABOVE IS CURRENT AND CORRECT TO THE BEST OF MY KNOWLEDGE.

PATIENT SIGNATURE (OR GUARDIAN, IF MINOR) DATE

DOCTOR SIGNATURE (AFTER REVIEWED WITH PATIENT) DATE