

WELCOME - The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out these forms completely. The better we communicate, the better we can care for you.

Patient's Name: _____ Birth Date: _____
 Address: _____ City: _____ State _____ Zip _____
 Email: _____ Home Phone: _____ Cell Phone: _____
 Place of Employment: _____ Business Phone: _____
 Physician's Name: _____ Phone Number: _____
 Marital Status: _____ Relationship to Insured: _____
 Dental Insurance Co. Name: _____
 Address: _____ Phone Number: _____ Group # _____
 Insurance Holder's Name: _____ Date of Birth: _____
 Place of Employment: _____
 How did you hear about us: _____

Person Financially Responsible For This Account: _____
 Address: _____
 Employment Name & Address: _____
 Home Phone: _____
 Social Security No/ID#: _____

Please check the best answer, and complete the blank lines where appropriate:

Has there been any change in your health in the last few years?..... Yes ___ No ___

Explain: _____

Check if you have had:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Lupus Erythematosus | <input type="checkbox"/> Emotional problems |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Transfusions | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Blood Pressure |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Drug reactions | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Allergies, Hives | <input type="checkbox"/> Venereal diseases | <input type="checkbox"/> Fainting, Dizziness |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Swollen Ankles | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Immune Sys. Diseases |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Sick headaches | <input type="checkbox"/> Hay fever |
| <input type="checkbox"/> Hepatitis (Type___) | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Cancer or tumors | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Radiation treatment | <input type="checkbox"/> Recent by-pass surgery | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pneumonia, lung or |
| <input type="checkbox"/> Liver problems | <input type="checkbox"/> Heart valve replacements | <input type="checkbox"/> Mental problems | breathing problems |
| <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Local anesthesia problems | <input type="checkbox"/> Viral infections, |
| <input type="checkbox"/> Weight ___ gain ___ loss | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Digestive problems | herpes, shingles, |
| <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Prosthetic joint replacements | <input type="checkbox"/> Heartburn | mononucleosis, |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hip ___ Knee ___ Etc. | <input type="checkbox"/> Cortisone medicines | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Angina | <input type="checkbox"/> Alcoholism |

Please list other conditions, diseases or problems not listed above

Are you taking or have you ever taken medicine for weak bones or osteoporosis?..... Yes No

Please list any medications and supplements you are currently taking; including frequency, dosage and purpose:

Are you allergic to jewelry, latex?..... Yes No

Are you allergic to any medications, drugs etc. such as local anesthetic, penicillin, sulfa, aspirin, codeine, other?..... Yes No

Are you pregnant? If YES, what is your due date?..... Yes No

How long since your last complete physical examination? _____

Do you smoke?..... Yes No

Have you had any injury to your face or jaw? Yes No

Are you conscious of bad breath or bad taste?..... Yes No

Do your gums bleed at times? Yes No

Do your teeth drift, move, or feel loose? Yes No

Have you ever had treatment for your gums? Yes No

Do you understand the meaning of periodontal disease? Yes No

Do you clench, grit, or grind your teeth? Yes No

Are you troubled with tension headaches, ear problems, aches or clicking in the jaw? Yes No

Is snoring an issue for you or your spouse?..... Yes No

Are you happy with your smile? Yes No

Do you desire to keep your natural teeth as long as possible? Yes No

How long has it been since you have been to a dentist? _____

Have you had difficulty associated with previous dental experiences? If YES, please explain

What are your greatest dental concerns at the present time?

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. To the best of my knowledge, all answers are correct. I will notify Dr. Sostowski if any changes in my health or medication should occur. I consent to necessary treatment being performed on me by Dr. Sostowski or his staff, and also to the use of photos for educational and commercial purposes.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA. I give my permission for Dr. Sostowski's office to leave messages regarding my appointments.

I understand that all responsibility for my payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1 1/2% finance charge (18% ARP) may be added to my account.

Please feel free to fully discuss your dental, medical, or financial concerns with us.

Patient's Signature: _____ Date: _____

Provider's Signature: _____ Date: _____