Welcome to our Practice

The following information will help us provide you with the highest standard of dental care. Please be assured that all information will remain confidential. We will happily assist you if you have any questions when filling out this form.

REGISTRATION INFORMATION

Date_____

First Name _____ Last Name_____ Date of Birth (MM/DD/YY) ___ / ___/ ____

Address: _____ City _____ Prov. _____ Postal Code _____

Phone: Home _____ Business _____ Cellular _____

What is the best way to contact you: Phone ____ E-mail___ Text Msg. ____ E-Mail Address: _____

Patients Care Card Number _____ Physician _____ Phone # _____

How did you hear about us? _____If you were referred, whom may we thank? _____

Emergency Contact _____ Phone: _____

Name of Guardian or Spouse _____

INSURANCE INFORMATION

Primary Dental Insurance	Secondary Dental Insurance
Subscriber's Name: _____	Subscriber's Name_____
Subscribers Date of Birth (MM/DD/YY) ___ / ___ /_____	Subscribers Date of Birth (MM/DD/YY) ___ / ___ /_____
Insurance Company: _____	Insurance Company: _____
Group/Policy # & ID #: _____	Group/Policy # & ID#: _____
% Basic/Major: _____	% Basic/Major: _____

OFFICE POLICIES

Appointments:

- Our office desires to be as prompt and on time as possible with all of our patients. If you are unable to keep your appointment, please notify us at least 2 business days in advance. This will allow us to schedule other patients awaiting treatment.

Financial:

- Payment is expected in full for services rendered at time of treatment unless previous financial arrangements have been made. We wish to be understanding of your financial needs and we will gladly discuss them with you. We accept Visa, Master Card, Direct Debit, Cash or Cheques.
- Dental Insurance: The particular plan which you have is a contract between yourself and the insurance company providing benefits. We provide the service of submitting claims to your insurance company. Please understand that many plans exist and all plans provide different levels of treatment coverage. It is your responsibility for any balance unpaid by your insurance.
- All fees quoted are estimates only and are subject to change.

Patient Authorization

I authorize release, to my dental plans administrator, information contained in claims submitted electronically.

I hereby assign my benefits, payable from claims submitted electronically to Dr. W. Sokolowski and authorize payment directly to him.

I have read and understand the above policies and consent to abide by them.

Signature of Patient: _____

Signature of Parent or Guardian: _____

Date: _____

MEDICAL HISTORY

	Yes	No
1. Are you presently under the care of a physician? _____	□	□
2. Have you been hospitalized or had any surgery done in the last two years? _____	□	□
3. Have you ever had a replacement (knee, hip, heart valve?) If so, when? _____	□	□
4. Have you had any serious injury to your head, neck, or back? _____	□	□
5. Do you bruise easily or bleed abnormally when cut? _____	□	□
6. Are you on blood thinners such as Aspirin, Warfarin, Plavix or other _____	□	□
7. Do you smoke or use smokeless tobacco? _____	□	□
If yes how many years?_____ Quantity per day?_____		
8. Do you have a pacemaker? _____	□	□
9. Female: Are you pregnant? _____	□	□
10. Female; Are you taking Birth Control or Hormone Replacement? _____	□	□
11. Are you taking any prescription or non-prescription medications?_____	□	□

NAME OF MEDICATION	REASON FOR USE

12. Have you experienced an allergic reaction to any of the following?

Penicillin	□	**Ibuprofen/Aspirin**	□	**Acetaminophen (Tylenol)**	□
Barbiturates (sleeping pills)	□	**Local Anesthetics**	□	**Fluoride**	□
Codeine	□	**Latex**	□	**Metal (Nickel, Gold, Silver)**	□
Tetracycline	□	**Sulfa**	□		

13. Have you ever had an adverse reaction to any other medication or substance? Y □ N □
If yes please specify: _____

14. Please check the appropriate box below if you have or had any of the following

□ A.I.D.S. /H.I.V.	□ Cold Sores (Herpetic Lesions)	□ Kidney Disease
□ Alcohol or Drug Dependency	□ Diabetes	□ Liver Disease
□ Anemia	□ Endocarditis	□ Low Blood Pressure
□ Angina (Chest Pain)	□ Emphysema (Lung Disease)	□ Mitral Valve Prolapse
□ Arthritis	□ Epilepsy/Seizures	□ Mental or Nervous Disorder (Depression)
□ Asthma	□ Fainting / Dizzy Spells	□ Organ Transplant
□ Blood Disorder	□ Glaucoma	□ Rheumatic / Scarlet Fever
□ Cancer	□ Heart Disease Heart Attack	□ Stomach / Intestinal Problems (Ulcers)
□ Chemotherapy or Radiotherapy	□ Hepatitis A / B / C (circle)	□ Stroke
□ Congenital Heart Defect	□ High Blood Pressure	□ Thyroid Problems

15. Do you have or had any condition not listed above? Y□ N□ If yes, please elaborate:
_____

Signature of Patient: _____

Date: _____

Doctors Notes: _____
_____

DENTAL HISTORY

Previous Dentist: _____ Last Dental Visit: _____ Last X-Ray :_____

What is your reason for today's visit? _____ _____

	YES	NO
1. Have you ever had any problems or difficulty with previous dental treatments?_____	□	□
2. Do you feel nervous about receiving dental treatment? How nervous, on scale 1(least) to 10(most)__	□	□
3. Have you ever had trouble getting numb or had any reaction to local anesthetic?_____	□	□
4. Are there any special considerations that would allow us to make you more comfortable here? _____	□	□
5. Are you having any pain or troubles with you teeth?_____	□	□
6. Are any teeth sensitive to hot, cold, sweets or biting? _____ _____	□	□
7. Do you frequently get food caught between any teeth?_____	□	□
8. Do you notice any holes (pitting) on the biting surface of your teeth?_____	□	□
9. Do you notice grooves or notches on your teeth near the gum line?_____	□	□
10. Have you ever broken teeth, chipped teeth, or cracked a filling?_____	□	□
11. Are your teeth developing spaces or become more loose?_____	□	□
12. Is there anything about the appearance of your teeth that you would like to change?_____	□	□
13. Have you ever had orthodontic treatment (braces)?_____	□	□
14. Do you feel like you have a dry mouth, too little saliva?_____	□	□
15. Do you experience discomfort or bleeding with your gums while brushing or flossing your teeth?___	□	□
16. Have you ever noticed an unpleasant taste or odor in your mouth?_____	□	□
17. Have you ever been treated for gum disease? _____	□	□
18. Have you noticed any of your teeth feel loose? _____	□	□
19. Do you or have you had any problems with your jaw joint? (pain, noise(cracking/popping), limitations in opening, locking)_____	□	□
20. Do you have any oral habits? (bite your nails, chew ice, using your teeth to hold objects)_____	□	□
21. Do you avoid or have difficulty chewing certain foods? (gum, carrots, nuts….other)_____	□	□
22. Do you wear or have ever worn a night guard appliance?_____	□	□
23. Do you require antibiotics before dental treatment?_____	□	□
24. Do you have or ever had any lumps or sores in your mouth? _____	□	□

Signature of Patient: _____

Date: _____