GENERAL DENTISTRY

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PATIENT INFORMATION:

Name____ Married___ Divorced___ Single___ Child___ Other___
Address ______________________________City_________________________ State____ Zip _____________
Home#:____________________________________ Work #:____________________________________
Cell#:____________________________________ Consent for text messaging: Yes____ No____
Email Address:____ Consent for email: Yes___ No___
Date of Birth:_______________ Social Security Number (not needed for minors):_______________________
Employer Name:________________________________ Occupation: ____________________________________

REFERRAL & PHARMACY INFORMATION:
Whom may we thank for referring you? ____
Pharmacy Name:__________________________________ Phone#:_____________________________________

ICE Contact / IN CASE OF EMERGENCY NOTIFY:
Name ____ Relation to Patient__________________________
Daytime Phone # ___________________________________

PRIMARY Dental Insurance:
Policy Owner's Name: ____DOB: __________________________
Relationship to patient:____
ID #/Social Security #: ____________________________Group/Policy #: _______________________________
Dental Insurance Plan Name: ____
Claims Address:____
Employer/Group Name: _____________________________________
Insurance Co. Phone#:____

SECONDARY Dental Insurance:
Policy Owner's Name: ____DOB: __________________________
Relationship to patient:____
ID #/Social Security #: ____________________________Group/Policy #: _______________________________
Dental Insurance Plan Name: ____
Claims Address:____
Employer/Group Name: _____________________________________
Insurance Co. Phone#:____

RESPONSIBLE PARTY INFORMATION (for minors or dependents of the patient)
Name ____ Relation to Patient__________________________
Address ____
City______________________________________ State________________ Zip ____________________________
Social Security Number ________________________________ Date of Birth ____________________________
Employer Name/Address ____
City______________________________________ State________________ Zip ____________________________

ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION:
I Authorize payment of dental benefits to Michael L Bydalek, DMD, for professional services rendered. I understand I am financially responsible for all charges not covered by my insurance and that my insurance claim is filed as a courtesy to me. I authorize the release of any and all information necessary to process my insurance claim.

Signature ____ **Date** ___________________

OVER PLEASE

MEDICAL HEALTH & HISTORY
This information is needed to help the doctor treat you safely. Please **Circle** any of the following which you have or had:

Anxiety
Alcohol Reaction
ALS / Lou Gehrigs
Alzheimer
Anemia/Blood Disorder
Arthritis/Rheumatism
Artificial Heart Valves
Artificial Joints: Specify______
Asthma
Autism
Autoimmune Disease
Back Problems
Blood Pressure- High or Low
Cancer/ Leukemia
Chemo/Radiation
Defibrillator
Diabetes; If yes what type?______
Dizziness/Fainting
Epilepsy
Excessive Bleeding
Fosamax RX History
Glaucoma
Hay Fever/Seasonal
Head Injuries
Headaches
Heart Defect
Heart Disease
Heart Murmur/MVP
Hemophilia
Herpetic Lesions/Cold Sores
HIV/Aids
Immunosuppression
Jaundice
Kidney trouble (dialysis)
Liver Disease
Multiple Sclerosis
MRSA Infection
Nervous Disorders
Organ Transplants; Specify______
Osteoporosis
Pacemaker
Parkinson's disease
Psychiatric Disorder
Reflux/GERD
Respiratory Problems
Rheumatic Fever
Seizures
Sinus Problems
Sleep Apnea
Stroke
Thyroid Problems
Tremors
Tuberculosis
Tumors

Please specify **any medical conditions** not listed: ____________________________________
Has a **Cardiologist, Orthopedic Surgeon, &/or any Medical Doctor** ever told you, that you need to take an **antibiotic prior to dental appointments? If yes, please specify**____________________________
Have you been a patient in the **hospital** or **emergency room** in the past two years? Y or N
Have you been **under the care of a physician** in the past two years? Y or N
Are you taking **aspirin** or any other **blood thinner**? Y or N
Are you taking any **steroid medication**? Y or N
Are you receiving **bisphosphonate treatment**? (Aredia and Zometa) Y or N
Have you ever had **chemo-therapy**? Y or N [If yes what is/was your start date and end dates? __________]
Have you ever had **radiation therapy**? Y or N [If yes what is/was your start date and end dates? ______]
(*Women*) Are you **pregnant** now? Y or N
(*Women*) Are you taking birth control pills? Y or N
Have you ever taken **Phen-Phen** to lose weight? Y or N
Do you **smoke**? Y or N

Please List all MEDICATIONS/Antibiotics & Over the Counter Supplements that you are taking:______________________________
____
____
____

Please List All ALLERGIES that you have. Including Medications, Food, Latex, etc.:
____
____
____
____

DENTAL HEALTH
Reason for visit______________________________ When was your last dental visit? ___________
Prior Dentist Name: ______________________________ telephone number: ____________________
Have you ever had any serious medical problem associated with previous dental treatment? Y or N
If so, explain: ____
How often do you brush your teeth? _______ Do you floss daily? Y or N
Do your gums bleed while brushing or flossing? Y or N Do you chew on one side of your mouth? Y or N
Do you feel twinges of pain when your teeth come in contact with hot, cold, sweets or sours? ____________
Do your gums feel tender or swollen? Y or N Do your jaws ever feel tired? Y or N
Do you clench or grind your jaws/teeth while sleeping or during the day? Y or N
Do your jaws "Pop" or "Click"? Y or N
Would your like to change anything about your smile? Y or N please explain: ______________________
____
Please add anything you feel is important: ____
____

Patient Name; please print: ____

Patient Signature: ______________________________ **Date**: ____________________