Dr. Daniel Czapek, D.M.D. _____

Today's Date _____

Patient Information (Section A)

Dr. Mr. Mrs. Ms _____ S M D W
(FIRST) (LAST) (MI) (MARITAL STATUS)

Address _____ How Long _____
(NUMBER) (STREET) (CITY) (STATE) (ZIP)

Date of Birth: _____/_____/_____ (If Patient is a minor parent/guardian must complete section B)

*Full Time Student Y__ N__ College or University attending? _____

Home No. ( )_____-_____ ☐ (Please check the preferred number you would like to be called at)

Work No. ( )_____-_____ ☐ E-Mail address _____

Cell No. ( )_____-_____ ☐ What name do you prefer to be called? _____

Employer Name _____

Occupation _____ How long with this employer _____

Whom may we thank for referring you? _____

Emergency Contact Information _____ Phone No. _____

Responsible Party Information (Section B)

(If same as above please skip to Section C)

Relationship to Patient _____

Dr. Mr. Mrs. Ms. _____ S M D W
(FIRST) (LAST) (MI) (MARITAL STATUS)

Address _____ How Long _____
(NUMBER) (STREET) (CITY) (STATE) (ZIP)

Date of Birth _____/_____/_____ Spouse's Name _____

Home No. ( )_____-_____ Work No. ( )_____-_____ Cell No. ( )_____-_____

Dental Insurance Information (Section C)

Name of Policy Holder _____ Relationship to Patient _____

Date of Birth _____/_____/_____ Social Security Number _____-_____-_____

Employer Name _____

Occupation _____ How long with this employer _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Insurance Co. Phone No. _____ ID Number _____

Do you carry a secondary dental insurance? Y____ N____ If YES please complete below.

Name of Policy Holder _____ Relationship to Patient _____

Date of Birth _____/_____/_____ Social Security Number _____-_____-_____

Employer Name _____

Occupation _____ How long with this employer _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Insurance Co. Phone No. _____ ID Number _____

HIPAA ACKNOWLEDGEMENT

Acknowledgement of receipt of Notice of Privacy Practices _____
(INITIAL) (DATE)

Consent for Use & Disclosure of Health Information _____
(INITIAL) (DATE)

*I am 18 years or older and a student. I give my permission to contact my Parent(s)/legal guardian to discuss dental treatment and all related information _____
(INITIAL) (DATE)

HEALTH HISTORY:

Physician's name _____ Specialty _____

Phone No. _____ Date last seen _____

Y N Have you been hospitalized within the last 10 years? What For _____

Y N Are you taking any medication(prescription, non-prescription, herbs, or vitamins)?_____

_____

Y N Do you have any allergies? Medication _____ Environmental_____

Y N Are you sensitive to or ever had a negative reaction to Novocaine___Penicillin___Latex___Iodine___Codeine_____

Aspirin___Sulfa___Other_____

Y N Do you have any prosthetic? (hip or joint replacement, pins, etc.)_____

Y N Are you required to take antibiotic premedication before dental procedures?_____

Y N Have you ever had heart/cardiac surgery?(Pacemaker, Stint, etc.)_____ Year Placed_____

Y N Are you pregnant? If yes, what trimester?_____Are you attempting pregnancy_____

Y N Do you smoke or use any tobacco product? _____ How long? _____

Y N Have you traveled outside of the United States within the last 12 months? Where?_____

Y N Have you ever been involved in a car accident? If yes, was a cervical collar worn?_____Dates_____

Y N Do you clench or grind at night?

Y N Do you experience frequent headaches?

HAS YOUR PHYSICIAN EVER INFORMED YOU OF THE FOLLOWING:

Y N Stomach or Intestinal problems

Y N Rheumatic fever

Y N Heart murmur

Y N Hepatitis Type A__ B__ C__

Y N Tuberculosis

Y N High or low blood pressure

Y N Tumors or growths

Y N Diabetes

Y N Respiratory disease (asthma, emphysema, etc.)

Y N Dental phobia or anxiety disorder

Y N Kidney disease

Y N Liver disease/Jaundice

Y N Seizures

Y N Heart disease or disorder

Y N HIV, ARC, or AIDS

Y N Herpes I or II,/Apthous ulcers

Y N Blood Disease, bleeder or slow healer

Y N Shingles Active__ Non-active__

Please explain any of the above_____

_____

Have you seen an: Orthodontist_____Periodontist_____

Have you whitened your teeth before?_____

SIGNATURE (PATIENT, RESPONSIBLE PARTY OR LEGAL GUARDIAN):

_____

_____

***YOUR SIGNATURE STATES INFORMATION PROVIDED IS ACCURATE AND TRUE** ****WHEN APPROPRIATE, A CREDIT BUREAU REPORT MAY BE OBTAINED**