ABOUT YOU

Today's Date: ______________

Name: ___________________________________ ___________________________ _____________ Male _____ Female _____
Last First Middle

Address: ____ Apt#: ________________________________

City/State: ____ ZIP Code: ____________________

Home Phone: _____________________________________ Cell Phone: ____

Birthdate: _________________________ Social Security #: ________________________________ Marital Status: S M D W

If Married, Spouse Name: ____ Phone: _______________________________

Who is responsible for this account? (If other than patient)_________________________________ Phone: __________________

Emergency Contact Name: ____ Phone: ____________________ Relationship: _________________

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Please tell us how you heard about our practice: ____

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INSURANCE INFORMATION

Insured Name: ____ Relationship to Patient: ___________________________________

Insured Person's Birth date: _____________ Social Security #: _____________________ Insured's Employer: ___________________________

Insurance Co. Name: ______________________________ Phone: _________________Group #: _______________ Policy/ID #: _______________

Insurance Co. Address: ____ City/State __________________________ ZIP ___________

DENTAL HISTORY

Last Dental Cleaning: ______________________ Last X-rays __________________________ Last Full mouth X-rays ____________

Reason for today's visit: __________________________________ How often do you have dental examinations? ________________

How often do you brush your teeth? ___________________________ How often do you floss? ______________________________

Are you apprehensive about dental treatment? **Y N**

Please check circle Y (yes) or N (no) if you have/had

Grind or clench your teeth? **Y N**

Discomfort when chewing? **Y N**

Headaches, ear aches, neck pain? **Y N**

Cigarette pipe or cigar smoke? **Y N**

Teeth or fillings breaking? **Y N**

Mouth breathing? **Y N**

Does food collect between your teeth? **Y N**

Bad breath or bad taste in your mouth? **Y N**

Growth or sore spots in mouth? **Y N**

Jaw joint pain? **Y N**

Sensitivity (hot, cold, pressure, sweets)? **Y N**

Bleeding, swollen, or irritated gums? **Y N**

Have you been told you have gum disease? **Y N**

GENERAL HEALTH INFORMATION

Have you had any of the following? Please circle Y (yes) or N (no)

Allergies	Y	N	Hay Fever	Y	N	Respiratory Treatment	Y	N
AIDS	Y	N	Head Injuries	Y	N	Radiation Treatment	Y	N
Anemia	Y	N	Heart Disease	Y	N	Rheumatic Fever	Y	N
Arthritis	Y	N	Heart Murmur	Y	N	Rheumatism	Y	N
Artificial Joints	Y	N	Hepatitis A B C	Y	N	Sinus Problem	Y	N
Artificial Heart Valve	Y	N	Jaundice	Y	N	Stomach Problems	Y	N
Asthma	Y	N	High Blood Pressure	Y	N	Stroke	Y	N
Blood Disease	Y	N	Kidney Disease	Y	N	Tuberculosis	Y	N
Cancer	Y	N	Liver Disease	Y	N	Tumors or Growth on Head / Neck	Y	N
Diabetes	Y	N	Mental Disorders	Y	N	Ulcers	Y	N
Dizziness	Y	N	Nervous Disorders	Y	N			
Excessive Bleeding	Y	N	Pacemaker	Y	N			
Epilepsy	Y	N						
Fainting	Y	N	**Are You Pregnant?**	Y	N	**Do You Smoke?**	Y	N
Glaucoma	Y	N	Due Date ___________			How much per day ________		

Are you **allergic** to any of the following? Please circle Y for yes and N for no.

Y	**N**	Aspirin
Y	**N**	Ibuprofen
Y	**N**	Sulfa Drugs/Sulfites/Sulfides
Y	**N**	Codeine
Y	**N**	Latex, Metals, and Plastics
Y	**N**	Local Anesthetics
Y	**N**	Other Medications Please List

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

Medicine: _______________________________________ Condition: ___________________

Medicine: _______________________________________ Condition: ___________________

Medicine: _______________________________________ Condition: ___________________

Medicine: _______________________________________ Condition: ___________________

Physicians Name: ____ Phone: ___________________________

To the best of my knowledge, all the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the Doctor on my next appointment without fail.

X____Date:_____________________

Signature of Patient, Parent or Guardian

I understand that I am responsible for payment of services rendered by the office of Beata Czechura, DMD, at the time of services and also responsible for paying any co-payment and deductible or fees that my insurance does not cover. In addition, certain insurance companies have annual limitation for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the particular plan's limitations in any plan year. **THIS DENTAL OFFICE DOES NOT RENDER SERVICES ON THE ASSUMPTION THAT CHARGES WILL BE PAID BY THE INSURANCE COMPANY.** The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period.

X____Date:_____________________

Signature

I hereby authorize the office of Beata Czechura, DMD, to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security number or any other information given to you. I agree that in the event this office or I, institute legal proceedings with respect to amounts owed by me for services rendered, the prevailing parting in such proceedings shall be entitled to recover all costs incurred, including reasonable attorney's fee. I grant my permission to you or your assignee to telephone me at home, or work to discuss matters related to this form.

X____Date:_____________________

Signature