



JOLANTA PAJEK, D.D.S

WELCOME!

**PATIENT INFORMATION** (Confidential)

Date \_\_\_\_\_

Name \_\_\_\_\_

Birthdate \_\_\_\_\_

Address \_\_\_\_\_

Social Security # \_\_\_\_\_

MINOR  SINGLE  MARRIED  SEPARATED

Telephone \_\_\_\_\_

DIVORCED  WIDOWED

Home

Cell

Work

Your E-Mail \_\_\_\_\_ Your Place of Employment \_\_\_\_\_

Married? Spouse's Name and Employer \_\_\_\_\_

Minor? Parent or Guardian's Name, Address and Telephone \_\_\_\_\_

College Student? YES NO If yes, name of School \_\_\_\_\_

Whom May We Thank for Referring You to us? \_\_\_\_\_

Person to contact IN CASE OF AN EMERGENCY \_\_\_\_\_ Telephone \_\_\_\_\_

**PAYMENT INFORMATION**

Same as above

Name of Person Responsible for this Account \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ Birthdate \_\_\_\_\_

Social Security # \_\_\_\_\_

Telephone \_\_\_\_\_ Drivers License # \_\_\_\_\_

Home

Cell

Work

Is the responsible party a current patient in this office? YES NO

**DENTAL INSURANCE INFORMATION**

Name of Policy Holder \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birthdate of Policy Holder \_\_\_\_\_ Social Security # of Policy Holder \_\_\_\_\_

Policy Holder Employer \_\_\_\_\_ Employer Telephone \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_

Address \_\_\_\_\_ ID # \_\_\_\_\_

➔ Do You Have Additional Dental Insurance? YES NO If yes, please complete the following:

Name of Policy Holder \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birthdate of Policy Holder \_\_\_\_\_ Social Security # of Policy Holder \_\_\_\_\_

Policy Holder Employer \_\_\_\_\_ Employer Telephone \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_

Address \_\_\_\_\_ ID # \_\_\_\_\_

## Patient MEDICAL HISTORY

- |   | YES                      | NO                       |  | YES                      | NO                       |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Are you under medical treatment now?   | <input type="checkbox"/> | <input type="checkbox"/> | 6. Do you have a history of alcohol or drug dependency?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been hospitalized for any surgical operation or serious illness in the last 5 years?           | <input type="checkbox"/> | <input type="checkbox"/> | 7. Are you allergic to or have you had any reactions to: |                          |                          |
| 3. Are you taking any medications, including non-prescription medicine?<br>Please list: _____<br>_____<br>_____ | <input type="checkbox"/> | <input type="checkbox"/> | Local Anesthetics (Novocain)                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you taking any bisphosphonate medication for osteoporosis or cancer treatment?<br>_____                  | <input type="checkbox"/> | <input type="checkbox"/> | Penicillin or any other antibiotics                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you use tobacco?  | <input type="checkbox"/> | <input type="checkbox"/> | Barbiturates   | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | Latex Rubber   | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | Sedatives  | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | Any Metal (e.g. nickel, mercury, etc)                    | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | Other _____  | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | 8. MEN ONLY:   |                          |                          |
|   |                          |                          | Do you use Viagra?                                       | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | 9. WOMEN ONLY:   |                          |                          |
|   |                          |                          | Are you pregnant/nursing?                                | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | Are you taking oral contraceptives?                      | <input type="checkbox"/> | <input type="checkbox"/> |

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Do you have or ever had any of the following? Please CIRCLE:

High/Low Blood Pressure	Heart Disease	Heart Murmur	Chest pains	Heart Attack	Cardiac Pacemaker
Stroke	Angina	Rheumatic Fever	Hay Fever/Allergies	Tuberculosis	Asthma
Emphysema	Glaucoma	Epilepsy/Seizures	Blood Disease	Cancer	Chemo/Radiation
Recent Weight Loss	Hepatitis	Arthritis	Liver Disease	Diabetes	Prosthetic Joints
Lung Disease	Kidney Disease	AIDS/HIV	STD	Thyroid Problem	
Stomach Troubles/Ulcers	Bacterial Endocarditis	Prosthetic Cardiac Valve	Congenital Heart Disease	Cardiac Transplant	
Other _____					

Name of Physician \_\_\_\_\_ Telephone \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

## Patient DENTAL HISTORY

Name and Address of Previous Dentist \_\_\_\_\_ Date of Last Exam \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ Date of Last Cleaning \_\_\_\_\_

- |   | YES                      | NO                       |   | YES                      | NO                       |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Do you have a toothache?                     | <input type="checkbox"/> | <input type="checkbox"/> | 8. Do you clench or grind your teeth?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are your teeth sensitive to hot or cold ?    | <input type="checkbox"/> | <input type="checkbox"/> | 9. Have you ever had any difficult extractions or prolonged bleeding in the past? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are your teeth sensitive to sweet or sour?   | <input type="checkbox"/> | <input type="checkbox"/> | 10. Have you had any orthodontic treatment?                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have any sores in your mouth?         | <input type="checkbox"/> | <input type="checkbox"/> | 11. Do you wear dentures or partials?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you had any head, neck or jaw injuries? | <input type="checkbox"/> | <input type="checkbox"/> | If so, date of placement _____  |                          |                          |
| 6. Have you have any jaw problems?              | <input type="checkbox"/> | <input type="checkbox"/> | 12. Do you like your smile?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have frequent headaches?              | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |

## Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Dr. Pajek to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefit otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X \_\_\_\_\_ Date: \_\_\_\_\_  
Signature of patient (or parent/guardian if minor)

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Dr. Jolanta Pajek \_\_\_\_\_ Date: \_\_\_\_\_