

Welcome

Thank you for selecting our office! To help us meet your dental health care needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask, we will be happy to help.

Patient Information (CONFIDENTIAL)

Date _____

Name _____ Nickname _____

Home Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

Social Security # _____ Birthdate _____

Check Appropriate Box: Single Married Other Email: _____

Patient's Employer _____ Work Phone _____

Whom May We Thank For Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Driver's License # _____ Birthdate _____ Work Phone _____

Is this Person Currently a Patient in our Office? Yes No

Dental Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____

Name of Employer _____ Work Phone _____

Insurance Company _____ Group # _____ Union or Local # _____

Insur. Co. Address _____ City _____ State _____ Zip _____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:

Name of Person Responsible for this Account _____ Relationship to Patient _____

Birthdate _____ Social Security # _____

Name of Employer _____ Work Phone _____

Insurance Company _____ Group # _____ Union or Local # _____

Insur. Co. Address _____ City _____ State _____ Zip _____

— OVER PLEASE —

MICHAEL P. FOLCK, D.D.S.
COSMETIC RESTORATIVE DENTISTRY

Patient Medical History

Name of Physician _____

	Yes	No		Yes	No
1. Are you under medical treatment now?.....	<input type="checkbox"/>	<input type="checkbox"/>	5. Do you use recreational drugs?.....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what for _____			6. Are you wearing contact lenses?.....	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized for any surgical operation or serious illness?.....	<input type="checkbox"/>	<input type="checkbox"/>	7. Are you allergic to or have you had any reactions to any medications? If so please list: _____	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what for _____			8. Have you taken weight loss medication that was prescribed by a physician?.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you taking any medications(s) including non-prescription medicine?.....	<input type="checkbox"/>	<input type="checkbox"/>	9. Women:		
If yes, what medication(s) are you taking?.....	<input type="checkbox"/>	<input type="checkbox"/>	a) Are you pregnant or think you may be pregnant?.....	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you use tobacco?.....	<input type="checkbox"/>	<input type="checkbox"/>	b) Are you nursing?.....	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have or have you had any of the following?			c) Are you taking birth control pills?.....	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No		Yes	No
High Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problem.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur.....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever.....	<input type="checkbox"/>	<input type="checkbox"/>	Angina.....	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles.....	<input type="checkbox"/>	<input type="checkbox"/>	Frequently Tired.....	<input type="checkbox"/>	<input type="checkbox"/>
Fainting / Seizures.....	<input type="checkbox"/>	<input type="checkbox"/>	Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy / Convulsions.....	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia.....	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement or Implant.....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis / Jaundice.....	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Diseases.....	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection.....	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Troubles / Ulcers.....	<input type="checkbox"/>	<input type="checkbox"/>
			Chest Pains.....	<input type="checkbox"/>	<input type="checkbox"/>
			Easily Winded.....	<input type="checkbox"/>	<input type="checkbox"/>
			Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>
			Hay Fever / Allergies.....	<input type="checkbox"/>	<input type="checkbox"/>
			Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>
			Radiation Therapy.....	<input type="checkbox"/>	<input type="checkbox"/>
			Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>
			Recent Weight Loss.....	<input type="checkbox"/>	<input type="checkbox"/>
			Liver Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
			Heart Trouble.....	<input type="checkbox"/>	<input type="checkbox"/>
			Respiratory Problems.....	<input type="checkbox"/>	<input type="checkbox"/>
			Other.....	<input type="checkbox"/>	<input type="checkbox"/>

Patient Dental History

	Yes	No		Yes	No
1. Do your gums bleed while brushing or flossing?.....	<input type="checkbox"/>	<input type="checkbox"/>	9. Do you clench or grind your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>
2. Are your teeth sensitive to hot or cold liquids/foods?...	<input type="checkbox"/>	<input type="checkbox"/>	10. Do you bite your lips or cheeks frequently?.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Are your teeth sensitive to sweet or sour liquids/foods?...	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you ever had any difficult extractions in the past?.....	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you feel pain to any of your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you had any orthodontic work?.....	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any sores or lumps in or near your mouth..	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you ever had any prolonged bleeding following extractions?.....	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you had any head, neck or jaw injuries?.....	<input type="checkbox"/>	<input type="checkbox"/>	14. Have you ever had instruction on the correct method of brushing your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever experienced any of the following problems in your jaw:			15. Have you ever had instruction on the care of your gums or told you had gum disease?.....	<input type="checkbox"/>	<input type="checkbox"/>
a) Clicking?.....	<input type="checkbox"/>	<input type="checkbox"/>	16. Due to your medical history, have you ever been required to take antibiotic pre-medication prior to dental procedures?.....	<input type="checkbox"/>	<input type="checkbox"/>
b) Pain (joint, ear, side of face)?.....	<input type="checkbox"/>	<input type="checkbox"/>			
c) Difficulty in opening or closing?.....	<input type="checkbox"/>	<input type="checkbox"/>			
d) Difficulty in chewing?.....	<input type="checkbox"/>	<input type="checkbox"/>			
8. Do you have frequent headaches?.....	<input type="checkbox"/>	<input type="checkbox"/>			

Please add anything you feel is important that may assist us in treating you _____

Authorization and Release

I certify that I have read and understand the above information. The above questions have been accurately answered. I understand that providing the incorrect information can be dangerous to my health. I authorize the dentist 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 payor and/or health care practitioners. I understand that I am personally, fully responsible for payment for services rendered. If dental insurance is expected to cover any part of the fees, all deductibles and co-payments will be paid by me at each visit. I understand my dental insurance carrier may pay less than the actual bill for services. I authorize and request my insurance company to pay directly to the dentist or dental insurance benefits otherwise payable to me. Accounts 30 days past due are subject to a late fee. I also understand I am responsible for all collection and/or legal fees in the event my financial arrangements are not kept. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient or parent, if minor, **X** _____ Date _____