Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Your Information

Last Name _____ First Name _____ Middle _____

Preferred Name: _____

Birthdate _____ SSN: _____

Gender? ◯ Male ◯ Female Married? ◯ Yes ◯ No

Address _____

Address 2 _____

City _____ State _____ ZIP _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email address? _____

What is the best way to contact you?

How would you like us to remind you of your appointments?

How would you like us to contact you for your check-up appointments?

Is there any way that you DO NOT wish to be contacted?

How did you hear about our practice?

If someone told you about our practice please tell us their name so that we may thank them:

Your personal preferences are important to us. Are you concerned about any of the following?

- None
- Amalgam
- Fluoride
- Sealants
- Dental anxiety

List Authorized Individuals that we can share personal information with and their relationship with you. (Examples of information: financial, treatment, appointments, scheduling)

Office Policies/HIPAA

For my convenience, this office may release my information to my insurance company, and receive payment directly from them.

All fees are due at the time of service unless other arrangements have been made. Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible. Please give 24 hour notice if you are unable to keep your reserved time. There will be a fee charged for missed appointments.

I have had the opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

I give consent for Dr. Mularczyk and the staff to carry out dental treatment on me or my child including xrays, teeth cleaning, fillings, fluoride treatments, photographs, and impressions. I understand that all treatment will be discussed with me first and I may decline any or all treatment at any time.

I knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic. I understand that the virus has a long incubation period during which carriers of this virus may not show symptoms and may still be highly contagious.

Patient/Guardian Signature

Date

Dental History

What brings you in today?

	Yes	No
Are you anxious about dental treatment?	○	○
Have you had problems with previous dental treatment?	○	○
Do you gag easily?	○	○
Do you have difficulty chewing food?	○	○
Do you chew on only one side of your mouth?	○	○
Do you have swollen or bleeding gums?	○	○
Have you ever noticed slow-healing sores in or about your mouth?	○	○
Are you having pain or sensitivity?	○	○

If yes - what are the symptoms?

- None
- Spontaneous pain
- Constant pain
- Occasional pain
- Mild or moderate pain
- Severe pain
- Sensitive to hot or cold
- Sensitive to biting/chewing
- Sensitive to sweets
- Swelling

	Yes	No
Do you clench or grind your teeth?	○	○
Do you wake up with tired jaws?	○	○
Do your jaws cause pain when opening or closing?	○	○
Are you aware of an uncomfortable bite?	○	○
Have you ever had a blow to the jaw (trauma)?	○	○
Does anyone in your home have severe decay/lots of cavities?	○	○
Do any relatives (your parents, grand-parents) have severe gum disease?	○	○

If you could change your smile - what would you change?

When was the last time you had a thorough exam and full set of x-rays?

What do you most often drink between meals:

How often do you brush? _____ times a day

How often do you floss? _____ times a week

Medical History

Do you see a physician regularly? ◯ Yes ◯ No

Have you been seriously ill or hospitalized in the past five years? ◯ Yes ◯ No

If yes, what for?

Please check next to any medical condition that you have, or had in the past.

- ☐ Heart Problems
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Pacemaker
- ☐ Artificial heart valve
- ☐ Abnormal bleeding
- ☐ Anemia/blood disease
- ☐ Allergies
- ☐ Skin problems
- ☐ Drug/alcohol abuse
- ☐ Sinus problems
- ☐ Asthma
- ☐ COPD
- ☐ Ulcers
- ☐ Reflux/chronic heartburn
- ☐ Kidney or bladder problems
- ☐ Arthritis
- ☐ Back or neck pain
- ☐ Joint replacement
- ☐ Osteoporosis
- ☐ Seizures or epilepsy
- ☐ Gastric bypass surgery
- ☐ Stroke
- ☐ Diabetes
- ☐ Tuberculosis
- ☐ Hepatitis or liver disease
- ☐ HIV/AIDS
- ☐ Glaucoma
- ☐ Neurological disease
- ☐ Frequent or severe headaches
- ☐ Thyroid problems
- ☐ Cancer or tumor
- ☐ Radiation treatment

Do you take any prescription or non-prescription medications? ◯ Yes ◯ No

If yes, please list here:

Do you have any allergies to drugs, medicines, or foods, or latex? ◯ Yes ◯ No

If yes, please list here:

Do you have sleep apnea? ○ Yes ○ No

Have you ever been diagnosed with a psychiatric disorder? ○ Yes ○ No

Do you smoke, or use other tobacco products? ○ Yes ○ No

If yes, please describe:

Do you have a chronic cough or hoarse voice? ○ Yes ○ No

Women, are you pregnant or nursing? ○ Yes ○ No

Do you have any disease, condition, or problem not listed previously that you feel we should know about? ○ Yes ○ No

If so, please describe:

The information I provided here is true and accurate to the best of my knowledge. If there are changes to my health or medicines, I will let this office know.

_____ _____

Patient/Guardian Signature Date