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.

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?

_____

_____

What do you most often drink <u>between</u> meals:

_____

When was your last exam and x-rays?

How often do you brush? _____ times per day

How often do floss? _____ times per week

_____

Medical History

Do you see a physician regularly? ◯ Yes ◯ No

Name of physician:_____

Address:_____Phone:_____

Do you require an antibiotic before a dental appointment: ◯ Yes ◯ No

If yes, what for (Medical condition):

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
- ☐ Birth Control
- ☐ 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 disease, condition, or problem not listed previously that you feel we should know about? ◯ Yes ◯ No

If so, please describe:

Do you have any allergies to drugs, medicines, food 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

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

Consent for Local Anesthesia

I understand that my dental treatment may require the use of a local anesthetic for pain control. I understand that a local anesthetic may consist of different medications that are injected into the cheek, jaw or gum area. These drugs may include lidocaine, prilocaine, mepivacaine, bupivacaine, articaine, or others. I understand that local anesthetics may contain "vasoconstrictor" like epinephrine; antioxidants, such as sulfites or methylparaben for preservation of the solutions; sodium hydroxide, and sodium chloride.

I understand that local anesthetics will cause a section of my mouth to become numb, with the numbness lasting up to several hours. I know that while my mouth is numb I must be careful not to bite my lips or tongue.

Local anesthetics are among the most common drugs used in a dental office. Complications and side effects are rare, but may include, among others not listed on this sheet:

- ☐ Swelling, bruising, or soreness at the injection site.
- ☐ A blood filled swelling called hematoma, can form when a needle used during an injection hits a blood vessel.
- ☐ Temporary numbness outside of the mouth making an eyelid or mouth "droop".
- ☐ Damage to the nerves resulting in temporary or possibly permanent numbness or tingling of lilps, chin, tongue or other areas.
- ☐ Severe and possible life threatening allergic reactions necessitating emergency care.
- ☐ Temporary rapid heartbeat.

I understand that if I have uncontrolled high blood pressure, uncontrolled thyroid problems, angina or have recently had a heart attack, I will inform the dental team without fail as these conditions have caused complications for persons receiving local anethesia. I will also inform the dental team of any prescription or over-the-counter medications I am taking as these may interact with local anesthetics. I understand the recommendation of local anesthetic for all the dental procedures that require adequate pain control, risks of the local anesthetics, any alternatives and risks of these alternatives, including consequences of doing nothing. This consent for local anesthetics remains valid every time I seek any treatment in this office. I had had all my questions answered, and have not been offered any guarnatees.

Patient/Guardian Signature _____ Date _____