Michael Niemzak, DMD

Soc. Sec. # _____

Patient Information (*confidential)*

Date _____

Name _____ Birth date _____ Home Phone _____

Single _____ Married _____ Divorced _____ Separated _____ Widowed _____ Mobile Phone _____

e-mail address_____

Address_____ City _____State _____ Zip _____

Patient's or Parent's Employer _____ Work Phone _____

Spouse or Parent's Name _____ Employer _____ Work Phone_____

Whom May We Thank for Referring You? _____

Person to contact in Case of Emergency _____ Phone _____

Person Responsible for this account _____ Relationship to Patient _____

Insurance Information

Name of Insured _____ Relationship to Patient _____

Social Security # of insured _____ Date Employed _____

Name of Employer _____ Work Phone _____

Address of Employer _____City _____ State _____ _ Zip _____

Insurance Company _____Group # _____ Union or Local # _____

DENTAL HISTORY

	yes	no		yes	no
Do your gums bleed while brushing or flossing?	___	___	Do you have frequent headaches?	___	___
Are Your teeth sensitive to hot or cold?	___	___	Do you clench or grind your teeth?	___	___
Do you feel pain to any of your teeth?	___	___	Have you had difficult extractions in the past?	___	___
Do you have any sores or lumps in your mouth?	___	___	Have you had prolonged bleeding after an extraction?	___	___
Have you ever had any head, neck or jaw injuries?	___	___	Have you ever had any orthodontic work?	___	___
Have you ever experienced pain in your jaw ? when chewing, opening, or closing?	___	___	Have you been instructed on the proper method of brushing and flossing?	___	___

Chief Oral Complaint _____

Date of last dental exam. _____ Any previous major dental treatment, yes ____ no___ When _____

MEDICAL HISTORY

Physician's name _____ Date of last physical exam. _____ Age _____

Allergies to drugs ___yes ___no Please list _____

	yes	no		yes	no		yes	no
Allergies to anesthetics	___	___	Diabetes	___	___	AIDS or HIV infection	___	___
Heart problems	___	___	Thyroid	___	___	Ulcer or Colitis	___	___
Joint Replacement	___	___	Malignancies	___	___	Tuberculosis	___	___
High Blood Pressure	___	___	Stroke	___	___	Pregnancy	___	___
Sexually Transmitted Diseases	___	___	Drug addiction	___	___	if so, what month?	_____	
Neurological problems	___	___	Psychiatric care	___	___	Sinus problems	___	___
Radiation treatments	___	___	Hepatitis	___	___	Hay Fever or allergies	___	___
Anemia or blood problems	___	___	Asthma	___	___			

List all medications you are taking _____

_____

_____

To the best of my knowledge the above confidential information is true. I understand that providing incorrect information could be dangerous to my health. I understand that my insurance company may pay less than the actual bill for services. If the above patient is a minor, I also give permission for treatment.

Signature _____ Date _____