WEST SIDE DENTAL CT, LLC
Dr. Sobieraj
Helping Families SMILE for over 30 years

WELCOME TO WEST SIDE DENTAL CT

To assist us in serving you, please complete the following confidential form.
The information provided is important to your dental health.

Patient's name _____ Birth date_____

If minor, parents' names _____ Home phone _____ Work/Cell phone _____

Home address: _____Email_____

Employer _____ Occupation _____

Marital Status: Unmarried Married Spouse/Partner's name _____

Whom may we thank for referring you to our office? _____

Emergency Contact Name and Phone Number:_____

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ Not covered by dental insurance

Your Social Security number: _____ Dental Insurance Co._____ Group number_____

Covered by spouse's insurance? ❑ yes ❑ no

Spouse's dental insurance company _____ Group number _____

Spouse's birthday _____ Social Security number _____

DO YOU HAVE ANY OF THE FOLLOWING DISEASES OR PROBLEMS?

ACTIVE TUBERCULOSIS	YES	NO	PERSISTENT COUGH GREATER THAN 3 WEEKS	YES	NO
COUGH THAT PRODUCES BLOOD	YES	NO	EXPOSED TO ANYONE WITH TUBERCULOSIS	YES	NO

IF YOU ANSWER YES TO ANY OF THE 4 ITEMS ABOVE, PLEASE STOP AND RETURN FORM TO RECEPTIONIST

DENTAL INFORMATION

DO YOU LIKE YOUR SMILE?				YES	NO
DO YOUR TEETH HURT?	YES	WHERE?_____			NO
DO YOUR GUMS BLEED WHEN YOU BRUSH OR FLOSS?				YES	NO
DOES FOOD OR FLOSS GET CAUGHT BETWEEN YOUR TEETH				YES	NO
IS YOUR MOUTH DRY?	YES	NO			
DOES YOUR JAW CLICK OR POP?		YES	NO		
DO YOU GRIND YOUR TEETH?	YES	NO			
HAVE YOU HAD GUM (PERIO) TREATMENT?		YES	NO		
HAVE YOU HAD ORTHODONTIC TREATMENT?		YES	NO		
WHEN WAS YOUR LAST DENTAL EXAM?		_____			

WHAT BRINGS YOU TO WEST SIDE DENTAL CT TODAY?

_____

IF YOU COULD CHANGE ***ANYTHING*** ABOUT YOUR SMILE, IT WOULD BE:

_____

MEDICAL HEALTH HISTORY

DATE OF LAST PHYSICAL EXAM:_____NAME OF PHYSICIAN: _____

- ARE YOU IN GOOD HEALTH YES NO
- HAVE THERE BEEN ANY CHANGES IN YOUR HEALTH HISTORY IN THE PAST YEAR? YES NO

PLEASE LIST YOUR MEDICATIONS (INCLUDE THE OVER-THE-COUNTER MEDICATIONS)

_____

_____

HAVE YOU HAD AN ORTHOPEDIC TOTAL JOINT (HIP-KNEE-ELBOW-FINGER) REPLACEMENT? YES NO

- IF SO, WHEN_____

HAVE YOU HAD ANY CARDIAC PRODEURES DONE? YES NO IF SO, WHEN:_____

ARE YOU TAKING OR SCHEDULED TO BEGIN TAKING MEDICATION FOR OSTEOPOROSIS OR PAGET'S DISEASE LIKE: FOSAMAX, AREDIA, ACTONEL, RECLAST, BONIVA, ZOMETA , NERIIXIA? YES NO

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer –Tumor- Radiation treatment
- ❑ Heart ailment-angina- heart surgery-heart attack
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma or difficulty breathing
- ❑ Glaucoma
- ❑ Shingles
- ❑ Thyroid disorder

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Are you interested in quitting? YES NO

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

If you require an EPI Pen you are required to bring it with you to all appointments

Women:

- ❑ May be pregnant
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff at West Side Dental CT, LLC to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. I understand that I am responsible for any payment and services rendered and for any co pays and deductibles that my insurance does not cover.

Signature Date

Please add anything else you would like us to know:

_____

Date:_____ Comments_____

Date:_____ Comments_____

Date:_____ Comments_____