PATIENT INFORMATION AND MEDICAL HISTORY

BLAZEK & COLLINGWOOD D.D.S., S.C.
401 D PILOT COURT – WAUKESHA, WI 53188

Today's Date: _____ Date of Birth: _____
Name: _____
How do you wish to be addressed? _____
Address: _____City: _____
State: _____ Zip: _____
Home Phone (w/area code): _____
Work Phone (w/area code): _____
Cell Phone (w/area code): _____
Can we confirm your appointments using text messaging? YES NO
Can we confirm your appointments using email? YES NO
Email: _____
Patient's/ Parent's Employer: _____
Spouse's/Parent's Name: _____ Spouse's/Parent's Phone: _____
Physician's Name: _____ Physician's Phone: _____
Date of Last Physical: _____ Person financially responsible for account: _____
Whom may we thank for the referral? _____

PRIMARY DENTAL INSURANCE

Policy Holder Name:	Policy Holder SS#:
Policy Holder Employer:	Policy Holder ID:
Policy Holder Employer Address:	
Policy Holder Phone: (w/area code)	Patient SS#:
Dental Insurance Name:	Dental Ins. Phone: (w/area code)
Dental Insurance Company City:	Dental Insurance Company State:
Group/Policy Number:	Policy Holder Date of Birth:
Relationship of Patient to Policy Holder:	

SECONDARY DENTAL INSURANCE

Policy Holder Name:	Policy Holder SS# :
Policy Holder Employer:	Policy Holder ID:
Policy Holder Employer Address:	
Policy Holder Phone: (w/area code)	Patient SS# :
Dental Insurance Name:	Dental Ins. Phone: (w/area code)
Dental Insurance Company City:	Dental Insurance Company State:
Group/Policy Number:	Policy Holder Date of Birth:
Relationship of Patient to Policy Holder:	

DO YOU REQUIRE A PREMEDICATION PRIOR TO ANY DENTAL TREATMENT?

YES NO

IF YES, What Antibiotic has been prescribed? _____

ALLERGIES: (Please list ALL including medication, food, jewelry, seasonal, etc.): _____

_____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? If YES, when?

Please add any explanations or additional information for any questions answered yes.

Y	N	**Artificial Joint/ Prosthetic Replacement**	Y	N	Hepatitis A, B, or C
Y	N	**Heart Murmur**	Y	N	Herpes / Cold Sores
Y	N	**Heart Trouble / Heart Attack**	Y	N	High Blood Pressure
Y	N	**Heart Valve Replacement**	Y	N	HIV / AIDS
Y	N	**Infusion Treatment (i.e. Remicade)**	Y	N	Hyperthyroidism / Hypothyroidism
Y	N	**Mitral Valve Prolapse**	Y	N	Hypoglycemia
Y	N	**Osteopenia/ Osteoporosis**	Y	N	Jaundice
Y	N	**Pacemaker**	Y	N	Kidney Problem
Y	N	**Rheumatic Fever**	Y	N	Latex Allergy
Y	N	**Pins, Screws, Plates**	Y	N	Liver Disease
Y	N	Acid Reflux /GERD	Y	N	Low Blood Pressure
Y	N	ADD / ADHD	Y	N	Major Operation/ Surgery
Y	N	Alcohol Dependency	Y	N	MRSA
Y	N	Alzheimer's / Dementia	Y	N	Multiple Sclerosis
Y	N	Anemia	Y	N	Muscular Dystrophy
Y	N	Angina / Pain in Chest	Y	N	Organ Transplant
Y	N	Anxiety / Panic Attacks	Y	N	Parkinson's Disease
Y	N	Arthritis	Y	N	Psychiatric Treatment
Y	N	Asthma	Y	N	Radiation Therapy
Y	N	Blood Transfusions	Y	N	Reaction to Dental Anesthetic
Y	N	Bleeding Disorder	Y	N	Reaction to Rubber Products
Y	N	Bulimia / Anorexia	Y	N	Serious Accident
Y	N	Cancer / Tumor	Y	N	Sexually Transmitted Disease
Y	N	Chemotherapy	Y	N	Shingles
Y	N	Chronic Fatigue Syndrome	Y	N	Shortness of Breath
Y	N	Cortisone Treatment	Y	N	Sinus Problems

Y	N	Cough (persistent)/ COPD	Y	N	Skin Reaction to Jewelry
Y	N	Depression	Y	N	Sleep Disorder/ Sleep Apnea
Y	N	Diabetes : Type: I II	Y	N	Snoring
Y	N	Dry Mouth	Y	N	Stroke
Y	N	Drug Dependency	Y	N	Strong Gag Reflex
Y	N	Emphysema / Lung Disease	Y	N	Swollen Ankles
Y	N	Epilepsy / Convulsions	Y	N	Taken Fen-Phen or Redux
Y	N	Fainting / Dizziness / Vertigo	Y	N	Tobacco Dependency
Y	N	Fibromyalgia	Y	N	Trauma to Face/Jaw
Y	N	Gastrointestinal Problems/Stomach	Y	N	Tuberculosis
Y	N	Glaucoma	Y	N	Ulcer
Y	N	Gout			
Y	N	Hearing Loss	Women:		
Y	N	**Are you currently under a doctor's care? Why?**	Y	N	Might you be Pregnant? Due Date:
Any other condition or comments that you feel we need to know to better meet your health and dental needs:			Y	N	Are you taking Birth Control?
					Are you nursing?

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING AND REASONS: (including aspirins & supplements)

Name of Medication	Reason for Taking Medication

PATIENT DENTAL HISTORY

BLAZEK & COLLINGWOOD D.D.S., S.C.
401 D PILOT COURT – WAUKESHA, WI 53188

Today's Date: _____

Name:		Age:
Previous Dentist (if new to our office):		Previous Dentist's Phone # (if new to our office):
Previous Dentist's Address (if new to our office):		
Last Dental Visit (if new to our office):	Last Full Series X-Rays (if new to our office):	Last Bitewing X-Rays (if new to our office):
Do you have a chief concern?		

PLEASE INDICATE YES OR NO: IF YES, PLEASE EXPLAIN

YES	NO	Are you presently in any dental pain?
YES	NO	Have you ever had an unpleasant dental experience in the past?
YES	NO	Have you lost any teeth? To what causes?
YES	NO	Have you ever had orthodontic treatment? When?
YES	NO	Have you ever had any previous trauma to your head, neck or jaw?
YES	NO	Do you have any growths or swelling in your mouth? How long have they existed?
YES	NO	Do you have any difficulty swallowing?
YES	NO	Do your gums bleed when you brush?
YES	NO	Do you avoid brushing any part of your mouth?
YES	NO	Have you ever been told you have gum disease / pyorrhea / periodontal disease?
YES	NO	Is any part of your mouth sensitive to temperature, pressure from biting, food or drink?

YES	NO	Do you have any parafunctional habits (nail biting, thumb sucking, teeth grinding, teeth clenching, snoring, etc.)
YES	NO	Do you have a burning sensation in your mouth?
YES	NO	Have you ever had a bad reaction to dental anesthetic?
YES	NO	Does food catch between your teeth?
YES	NO	Do you have any pain or soreness around your eyes, ears or other parts of your face?
YES	NO	Are you aware of stiff neck muscles?
YES	NO	Do you ever awaken with an awareness of your teeth or jaw?
YES	NO	Are you aware of clenching your teeth or been told you grind at night? How often?
YES	NO	Do you experience any dry mouth?
YES	NO	Are you aware of your jaw clicking or popping while eating or yawning? How often? Pain?
YES	NO	Do you have difficulty opening your mouth widely?
YES	NO	Do you have tension headaches? How often?
YES	NO	Do you have an unpleasant taste in your mouth?
YES	NO	Do you have an overactive gag reflex?
YES	NO	Are you dissatisfied with your smile or appearance of your teeth?
YES	NO	Are you interested in whitening your teeth?
YES	NO	Do any members of your family wear partials or dentures?
YES	NO	Do any members of your family have periodontal / gum disease?
YES	NO	Do you feel you have any dental disease present?
YES	NO	Do you want to learn to control dental disease and retain your teeth?
YES	NO	Are you deeply concerned about the finances required to return / maintain your mouth to excellent dental health?

Medical History, Dental Services, Insurance Authorization, and HIPAA

The above medical history and information is correct, and I will advise your office of any future changes. I authorize release of any information relating to treatment. I understand I am responsible for all charges to my account. I understand that Blazek & Collingwood D.D.S., S.C. requests my full account balance to be paid at the time of service. In return, they apply a 5% courtesy. They will help me submit to my insurance, so I receive prompt reimbursement. I also have read and agree with the HIPAA policy of Blazek & Collingwood D.D.S., S.C. and understand a copy of the policy is available on their website for my reviewing at any time.

SIGNED: _____ Date: _____

Photo and Testimonial Release

I, _____, hereby grant permission to Blazek & Collingwood D.D.S., S.C. to use my photograph and any testimonial I give regarding the dental care I receive from any such office, in any marketing, advertising or teaching materials used to market or advertise their dental practice, including use on their website. I acknowledge Blazek & Collingwood D.D.S., S.C.'s right to crop or otherwise treat the photograph at their discretion. I also acknowledge that Blazek & Collingwood D.D.S., S.C. may choose not to use my photograph and/or testimonial at this time, but may do so at their own discretion at a later date. I also understand that once my image is posted on Blazek & Collingwood D.D.S., S.C.'s website, the image can be downloaded by any computer user, which is beyond the control of Blazek & Collingwood D.D.S., S.C. and I will hold them and any of their affiliated offices harmless from any such use or downloads.

I hereby freely and voluntarily consent to the use of my photograph and/or testimonial as stated above until I revoke this consent in writing.

Signature: _____ Date: _____

(Parent/Guardian if patient under age 18)

Printed Name: _____ Date: _____

(Parent/Guardian if patient under age 18)

To revoke this consent in writing please contact:

Blazek & Collingwood D.D.S., S.C.
401 D Pilot Court
Waukesha, WI 53188
262-542-2970

FOR OFFICE USE ONLY

Date:	Changes:	Provider Initials:	Patient Initials:
Date:	Changes:	Provider Initials:	Patient Initials:
Date:	Changes:	Provider Initials:	Patient Initials:
Date:	Changes:	Provider Initials:	Patient Initials:
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