WANEZEK FAMILY DENTISTRY

Patient Information

Patient Name:_____ DOB:_____
Last First MI Preferred Name

Health History

Name of Physician:_____Phone:_____Date last seen:_____
Are you now under the care of a physician? □Yes □ No
Have you been admitted to a hospital or needed emergency care during the past two years? □ Yes □ No
Please list any medications you are currently taking: _____
If there are too many medications to list here please ask for an additional medication page for more space.
Please list any medications you are allergic to:_____

Are you currently experiencing or have any of the following? Please check those that apply:

□ Acid Reflux	□ Ceclor Allergy	□ Head Injuries	□ Local Anesthetic	□ Respiratory Problems
□ Allergies	□ Cholesterol	□ Hearing Loss	□ Lorabid	□ Rheumatic Fever
□ Amoxicillin Allergy	□ Codeine Allergy	□ Heart Condition	□ Mental Disorders	□ Rheumatism
□ Anemia	□ Coumadin	□ Heart Disease	□ Mepivacaine	□ Sinus Problems
□ Arthritis	□ Diabetes	□ Heart Murmur	□ Mitral Valve Prolaps	□ Stent
□ Artificial Joints	□ Dizziness	□ Heart Valve Rplcment	□ Nervous Disorders	□ Stomach Problems
□ Asprin allergy	□ Epilepsy	□ Hepatitis A, B or C	□ Pacemaker	□ Stroke
□ Asthma	□ Erythromycin Allergy	□ Hi/Lo Blood Pressure	□ Parkinsons	□ Sulfa Allergy
□ Augmenton allergy	□ Excessive Bleeding	□ HIV/AIDS	□ Penicillin Allergy	□ Thyroid Problems
□ Blood Disease	□ Fainting	□ Kidney Disease	□ Pregnancy	□ Tuberculosis
□ Blood Thinner	□ Glaucoma	□ Latex Allergy	□ Prosthetic Replcmt.	□ Tumors
□ Cancer	□ Hay Fever	□ Liver Disease	□ Radiation Treatment	□ Ulcers

Do you smoke or chew tobacco? □ Yes □ No
Have you taken any prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products? □ Yes □ No
Have you been treated previously with any bisphosphonate drugs? (ex. Fosamax, Boniva) □Yes □ No
Do you have any health problems that need further clarification? □ Yes □ No

Dental History

Date of Last Dental Visit:_____ Reason for todays visit: □ New Patient Exam □ ER □ Consultation □ Other:_____
Are you having pain or discomfort at this time? □ Yes □ No
Do you brush and floss daily? □ Yes □ No
Are you unhappy with the appearance of your teeth? □ Yes □ No
Are you nervous or apprehensive about your dental treatment? □ Yes □ No
Have you ever had any complications following dental treatment? □ Yes □ No
Have you ever had an unusual reaction to dental anesthetic? □ Yes □ No

Do you have or have you ever had any of the following? Please check those that apply:

□ Bleeding or sore gums □ Food trapped between teeth □ Periodontal (gum) treatment □ Clenching or grinding teeth
□ Loose/shifting teeth □ Sensitivity to hot/cold/sweets □ Pain/clicking/popping of jaw □ Orthodontic treatment
□ Complications from extractions

Health Questionnaire Acknowledgment and Consent to Proceed

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment. I authorize Wanezek Family Dentistry and/or such associates or assistants as they may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative, analgesic, therapeutic, and /or other pharmaceutical agent, including those related to restorative, palliative, therapeutic or surgical treatments. I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, temporary or permanent numbness, and muscle soreness. I understand that with all dental procedures teeth may remain sensitive both during and after treatment. I do voluntarily assume any and all possible risks that may be associated with all dental procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Signature:_____Date:_____
Signature of Patient, parent or guardian

Doctor Signature:_____Date:_____