Drs. Potempa, Dick & Riad

5875 Snyder Drive Lockport, New York 14094 **261 Young Street Wilson, New York 14172**

Date_____ **Social Security #**_____ **Date of Birth**_____

Name _____

first name middle initial last name

Address_____ **Home Phone**_____ **Cellular phone#**_____

City_____ **State**_____ **Zip**_____

Employer_____ **Business Phone**_____

Business Address_____

Referred By_____ **Email address**_____

In case of emergency, who should we contact?_____ **Phone**_____

Dental Insurance?____ **Insurance Co.**_____

How long since you have been to a Dentist?_____ **Former Dentist**_____

Purpose of Call: _____

Person Responsible for Account_____

Relationship to

Patient_____ **Birthdate**_____ **Soc.Sec.#**_____

Address_____ **Home Phone**_____

City_____ **State**_____ **Zip**_____

Responsible Party Employed By_____ **Business Phone**_____

Business

Address_____ **Occupation**_____

Insurance Company_____

Subscriber I.D.#_____ **Group#**_____

ADDITIONAL INSURANCE

Insured Name_____

Relationship to Patient_____ Birthdate_____ Soc.Sec.#_____

Address_____ Home Phone_____

City_____ State_____ Zip_____

Insured Employed By_____ Business Phone_____

InsuranceCompany_____ Subscriber I..D._____

Group#_____

In the following questions, check yes or no, whichever applies. Your answers are for our records and will be considered confidential.

	YES	NO
1.Are you in good health?.....	____	____
a. Has there been any change in your general health within the past year ?.....	____	____
2.My last physical exam was on:		
3. Are you now under the care of a physician.....	____	____
a. If so, what it the condition being treated ?		
4. The name and address of my physician		
5. Have you had any serious illness or operation ?.....	____	____
If so when ? _____		
6. Do you have any prosthetic devices in your body ? (example: hip replacement, pins, heart valves, etc.?)	____	____
7. Do you have or have you had any of the following diseases	____	____
a. Rheumatic fever or mitral valve prolapse.....	____	____
b. Congenital heart lesions.....	____	____
c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke, heart murmur, hypertension.)		
d. Allergy, (example, penicillin, antibiotics, latex, other).....	____	____
e. Asthma or hay fever.....	____	____
f. H.....		

g. Fainting spells or seizures.....
h.Diabetes.....
i. Adverse reaction to anesthesia,(e.g. novocaine/ heart beat fast|immunosuppression)
j. Arthritis.....
k. Inflammatory rheumatism (painful, swollen joints).....
l. Kidney Trouble.....
m. Tuberculosis.....
n. Venereal disease.....
o. Hepatitis, jaundice or liver disease.....
p. Other:

8. Have you had abnormal bleeding associated with previous extractions, surgery or trauma
a. Do you bruise easily.....
b. Have you ever required a blood transfusion.....
If so, explain the circumstances

9. Do you have any blood disorder such as anemia?

10. Have you had surgery or x-ray treatment of your head or neck?
(radiation or chemotherapy).....
a. If so, what: (example-antibiotics, aspirin, blood pressure medication)

11. Are you taking any drugs or medicines.....
a. If so, what: (example-antibiotics, aspirin, blood pressure medication)

12. Have you had any serious trouble associated with any previous dental treatment.....
If so, explain

13. Are you HIV Positive? .....
a. Do you suspect that you may have been exposed to the AIDS virus ?.....

14. Do you have any disease, condition, or problem not listed above

15. WOMEN:
a:.Are you pregnant.....
b: Are you taking Birth Control pills.....

16. TEMPOROMANDIBULAR JOINT DYSFUNCTION
Do you suffer from any of the following condition:
a. Headaches.....
b. Dizziness.....
c. Ear pain.....
d. Ringing, buzzing or other sounds in the area.....
e. Difficulty opening or closing your mouth.....
f. Has your jaw ever locked or slipped out of place ?.....
g. Clicking sounds from your jaw joint.....
h. Pain from the jaw joint.....
i. Clench or grind your teeth - Day or night or both .....
j. Sports injuries, recent injuries.....
k. Sleep - restlessness, insomnia

***INSURANCE: To avoid misunderstandings regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies, upon receipt of full (or partial) payment of bill. We do not render our services on the basis that insurance companies will pay all our fees.**

Dentist's Signature **Date** **Patient's Signature** **Date**