WELCOME TO LIGOCKI DENTAL GROUP

Thank you for choosing Ligocki Dental Group for you and your family. Please fill out this form as completely as you can. If you have and questions, we will be glad to help.

PATIENT INFORMATION Today's Date: ____________________

Name: ______________________________________ [ ] Dr. [ ] Mr. [ ] Mrs. [ ] Ms. [ ] Other: ____________

Preferred Name: ______________________________ DOB: __________________ SSN: _________________

Occupation: ____ [ ] Male [ ] Female

Address: ____

City: ____ State: _____________ Zip Code: _____________

Home Phone: __________________ Cell Phone: ___________________ Email: _________________________

Employer: ____ Work Phone: ____________________

Are you: [ ] Minor [ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Widowed

Spouse Name: ____ Cell Phone: ____________________

Spouse's Occupation: ____

Are you a full time student? [ ] No [ ] Yes, Name of school: ____

RESPONSIBLE PARTY

Name: ____ Relationship: ___________________

Address: ____

City: ____ State: _____________ Zip Code: _____________

Home Phone: __________________ Cell Phone: ___________________ Email: _________________________

MEDICAL INSURANCE

Subscriber's Name: ____ Relationship: __________________

DOB: ___________________ Subscriber's SSN: ___________________ Employer: _____________________

Insurance Company: __________________________ Policy #: _______________ Group #: _______________

DENTAL INSURANCE

Insured Name: ____ Relationship: __________________

DOB: ______________________ SSN: ___________________________ Employer: _____________________

Insurance Company: __________________________ Policy #: _______________ Eff. Date: _______________

YOUR PREFERENCES

Do you prefer your appointment reminders by: [ ] Email [ ] Phone [ ] Text

Do you prefer to receive calls from our office at: [ ] Cell [ ] Home [ ] Work

Would you like to receive our emailed newsletters and news texts? [ ] Yes [ ] No

Whom may we thank for referring you? ____

Our mission is to provide our patients with the finest dental care while meeting our extraordinary standards through the use of innovative technology. In a warm, caring, and family atmosphere, we strive to deliver the highest standard of treatment that is tailored specifically to each individual's wants and needs. We are dedicated to fostering relationships with our patients and community while educating them to maintain a healthy body and smile for a lifetime.

 Reviewed by: _______________

MEDICAL HISTORY AND CONSENT

Although dental personnel treat the area in and around your mouth, your mouth is a part of your entire body. Health conditions or problems that you may have or had, or medications that you may be taking, could have an important interrelationship with the treatment you will receive. Thank you for answering the following questions.

ALLERGIES

Acrylics Y N
Anaphylaxis Y N
Latex Y N
Local Anesthetics Y N
Penicillin Y N
Metal Y N
Sulpha Y N
Other Y N
List other known allergies:

____
____
____

CARDIOVASCULAR

Artificial Heart Valve Y N
Coronary Artery Disease Y N
Chest Pain or Angina Y N
Congestive Heart Failure Y N
Heart Attack Y N
Heart Murmur Y N
High Blood Pressure Y N
High Cholesterol Y N
Irregular Heartbeat Y N
Low Blood Pressure Y N
Mitral Valve Prolapse Y N
Pacemaker Y N
Tachycardia Y N

ENDOCRINE

Diabetes Y N
Gout Y N
Hormonal Change Y N
Thyroid problems Y N

EYES, EARS, NOSE, & THROAT

Change in Hearing Y N
Change in Vision Y N
Dysphagia Y N
Ear Pain Y N
Glaucoma Y N
Hay Fever Y N
Nasal Obstruction Y N
Nose Bleeding Y N
Sinus Problems Y N
Tonsillectomy Y N
Tinnitus Y N

GASTROINTESTINAL

Acid Reflux Y N
GERD Y N
Soft or Special Diet Y N
Ulcers Y N

GENITOURINARY

Frequent Urination Y N
Kidney disease Y N
Nocturia Y N

GENERAL

Current weight: ____________lbs
Height: ________ ft ________in
Cancer Y N
Fatigue/Tired Y N
General Weakness Y N
Headaches Y N
HIV/AIDS Y N
Knee/hip replacement Y N
Liver problems Y N
Recent Trauma or Injury Y N
Rheumatic Fever Y N
Radiation Treatment Y N
Weight Change Y N
HPV Y N

HEMATOLOGICAL

Bleeding problems Y N
Hepatitis Y N

ORAL

Bleeding gums Y N
Dry mouth Y N
Jaw problems (TMJ)? Y N
Clicking? Y N
Pain? Y N
Difficulty swallowing? Y N
Difficulty chewing? Y N
Orthodontics Y N
Periodontal Disease Y N
Teeth clenching Y N
Teeth grinding Y N
Tooth pain Y N
Wisdom teeth extraction Y N
Do you wear removable teeth? Y N
Do you take or need antibiotics before dental procedures? Y N
Dental implants? Y N

MUSCULOSKELETAL

Back Pain Y N
Fibromyalgia Y N
Joint Pain Y N

NEUROLOGICAL

Alzheimer's Disease Y N
Dizziness Y N
Fainting Y N
Memory Loss Y N
Multiple Sclerosis (MS) Y N
Muscle Weakness Y N
Seizures Y N
Stroke Y N
Tingling/Numbness Y N
Trigeminal Neuralgia Y N
Tremor Y N

PSYCHIATRIC

ADD/ADHD Y N
Anxiety Y N
Chemical Dependency Y N
Depression Y N
Eating disorders Y N
Excessive Stress Y N
Memory problems Y N

RESPIRATORY

Asthma Y N
Bronchitis Y N
Breathing problems Y N
Chest Pressure Y N
Congestion Y N
Dyspnea (shortness of breath) Y N
Emphysema Y N
Orthopnea Y N
Pneumonia Y N
Pulmonary Embolism Y N
Tuberculosis Y N

SLEEP

Daytime Sleepiness Y N
Morning headaches Y N
Obstructive Sleep Apnea Y N
Do you use a CPAP? Y N
How often? _______________
Has anyone told you that you snore? Y N

SOCIAL HISTORY

Do you smoke? Y N If yes, _____ packs a day
Do you use smokeless tobacco? Y N
Do you consume alcoholic beverages? _____ drinks per week
Do you use recreational drugs? Y N
Do you have/had an eating disorder? Y N
Do you have piercings other than ears? Y N

LIST ANY MEDICATIONS YOU ARE TAKING:

	Medication	Dosage/Frequency	Prescriber	Reason
1.				
2.				
3.				
4.				
5.				
6.				

LIST ANY SURGERIES OR HOSPITALIZATIONS YOU HAVE HAD:

Date (year)	Surgery	Surgeon	Reason

LIST AND DETAIL ANY MEDICAL CONDITION OR HISTORY NOT LISTED ABOVE:

____

____

____

Primary Physician's Name: ______________________ Physician's phone number: ______________

ARE YOU UNDER THE CARE OF OTHER PHYSICIANS? IF SO, PLEASE LIST:

Physician	Phone #	Reason

CONSENT

To the best of my knowledge, all of the preceding information is correct and if there is ever any change in my health or medications Ligocki Dental Group will be informed of the changes without fail. I also consent to allow Ligocki Dental Group to contact any healthcare provider and to have the above named patient's health information released to aid in care and treatment. I also hereby consent to allow diagnosis, proper healthcare and treatment to be performed by Ligocki Dental Group for the above named individual until further notice.
I understand there are no guarantees or warranties in health or dental care.

NAME OF PATIENT/GUARDIAN: ______________________ RELATIONSHIP: __________

SIGNATURE: ______________________ DATE: __________

(Parent or guardian, if patient is a minor)

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