LIGOCKI DENTAL GROUP

Patient Information

Today's Date: ______________________________

Patient's Name: ____ **Date of Birth:** ______________________

Preferred Name:______________________________ **Social Security Number**:_______________________________

Home Address:____

City:_______________________________________**State**:__________________**Zip Code**:_____________________

Home Phone:____________________________________ **Mobile Phone**:___________________________________

E-mail Address:____

Medical Insurance:____

Group/Plan Number:________________________ **Patient Identification #**__________________________

Dental Insurance:____

Group/Plan Number:________________________ **Patient Identification #**__________________________

Occupation:_____________________________________ **Employer**:______________________________________

Work Number:____

Spouse Name:_______________________________________ **Date of Birth**:______________________________

Social Security Number:_______________________________ Employer:___________________________________

Occupation:____ Phone: ____________________________________

Emergency Contact: (If not listed above)

Name:______________________________________ Phone:_____________________ Relationship:_______________

If you are completing this form for another person:

Your Name:________________________________ Phone:_______________________ Relationship:_______________

Referred By:____

Would You Like To Receive Reminders and Newsletters via…? (Circle all that apply)

E-MAIL TEXT CALL

I consent to the dental procedures and anesthetics are necessary for the treatment of the above named patient. I also agree to assume full financial responsibility for all treatment rendered.

Signature:____ **Date**:______________________________

Continue on to the next page…

Reviewed by: __________________________

LIGOCKI DENTAL GROUP

Health Information and History

Today's Date: ____________________

Patient's Name: ____ **Date of Birth:** ______________________

If you are completing this form for another person:

Your name: _________________________________ Phone: __________________ Relationship: _______________

Date of your last dental visit: _____________ **Dentist's Name**: __________________ **City & State:** ______________

Primary Physician: ____________________________ **Phone:** __________________ **City & State:** _______________

Date of last physical exam: _____________________ Date of last blood test/work up: _________________________

Other Physicians & Specialists:

Name: _____________________ Specialty: ________________ Phone: ______________ City & State: _________________

Name: _____________________ Specialty: ________________ Phone: ______________ City & State: _________________

1. In the last 3 years, have you been hospitalized or had surgery? **Yes** **No**

If Yes, please give reasons and dates: ____

2. Have you ever been told to take ANY PRE-MEDICATIONS or take ANY special precautions before any dental appointments? **Yes** **No**

If Yes, please explain: ____

3. Are you taking ANY drugs, medications, or treatments at this time? **Yes** **No**

(If you brought a list, please give it to the receptionist instead)

Prescribed: ____

____

Over-the-counter (OTC) medications (such as Aspirin, Advil, allergy medication, sleeping aids, etc):

____

Vitamins, natural or herbal preparations and/or dietary supplements:

____

Are you having or have you ever had radiation or chemotherapy treatments? **Yes** **No**

If Yes, for how long? _________ Name of facility performing the treatment: ______________________________

4. Are you taking or have you ever taken Bisphosphonate (Fosamax)? **Yes** **No**

5. Are you allergic to or have you ever had an unusual reaction to:

___No Allergic Reactions or Allergies

___Latex ___Metals or jewelry ___Dental anesthesia (local)

___Fluoride ___Nitrous oxide (laughing gas) ___General anesthesia

6. Are you allergic to or have you had any reaction to any of the following drugs?

___No Allergies to drugs

___Penicillin (or related drugs) ___Tranquilizers (Valium) ___Tetracycline ___Codeine

___Aspirin/ibuprofen (Advil, Motrin, Nuprin) ___Keflex (Cephalexin) ___Sulfa drugs ___Iodine

___NSAID (Celebrex, Vioxx, Anaprox) ___Clindamycin (Cleocin) ___Erythromycin

7. Have you had an allergic reaction or unusual response to ANY other medications, drugs, pills, or treatments? **Yes** **No**

If Yes, please list: ____

Continue on to the next page…

Reviewed by: ________________________

LIGOCKI DENTAL GROUP

Health information and History (continued)

Patient's Name: ____

8. Do you have, or have you ever had, any of the following? (Please check Yes or No for each question)

	Yes	No
Congenital heart defects	___	___
Angina or chest pains	___	___
Atherosclerosis	___	___
Congestive heart failure	___	___
Coronary artery disease	___	___
Heart surgery	___	___
If Yes, type & date_____________________		
Heart Attack	___	___
If Yes, date____________________________		
Rheumatic heart disease/ rheumatic fever	___	___
Infective Endocarditis	___	___
Heart valve(s) damage/Mitral valve proplapse	___	___
Artificial heart valve Date: _____________	___	___
Pacemaker Date: _____________	___	___
Stroke or CVA Date:_____________	___	___
High Blood Pressure	___	___
Low Blood Pressure	___	___
Anemia	___	___
Hemophilia or bleeding disorder	___	___
Excessive bleeding from any cut or incident	___	___
Diabetes or blood sugar problems	___	___
Any artificial joints, joint surgery, or prosthesis	___	___
If Yes, what joint or area: ________________		
When was operation done: ________________		
Hepatitis, jaundice, or other liver problems	___	___
Any form of cancer: ____________________	___	___
An organ transplant: Date: _______________	___	___

	Yes	No
Asthma	___	___
Allergies, Hay Fever, skin or food allergies	___	___
Sinus problems	___	___
Tuberculosis, emphysema/lung disorder	___	___
Thyroid disease/problem	___	___
Skin problems or wounds that bleed easily or do not heal	___	___
Arthritis	___	___
Glaucoma or any eye diseases	___	___
Epilepsy or other seizure disorder	___	___
Any kidney problems	___	___
Ulcers, acid reflux, or stomach problems	___	___
A compromised immune system (Lupus, HIV, AIDS, radiation immune problem, etc.)	___	___
An active sexually transmitted disease (STD)	___	___
Any mental health issues	___	___
Been treated for any psychiatric condition	___	___
WOMEN ONLY:	**Yes**	**No**
Are you pregnant?	___	___
If Yes, when is your due date____________________________		
Do you think you might be pregnant?	___	___
Are you currently nursing?	___	___
Are you using birth control medication?	___	___
Are you taking hormone replacement therapy?	___	___
Any family history of cancer? Type_______________________		

9. Do you have any other conditions, diseases, or medical problems, or is there ANY other information that you would like us to know about, or that we should be made aware of? **Yes** **No**

If Yes, please explain: ____

____

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, this practice will be informed of the changes without fail. I also consent to allow this practice to contact any healthcare provider(s) and to have the patient's health information released to aid in care and treatment. I also hereby consent to allow diagnosis, proper health care and treatment to be performed by this practice for the above named individual until further notice.
I understand there are no guarantees or warranties in health or dental care.

Signature: ____Date_____________________________

(Parent or guardian, if patient is a minor)

Continue on to the next page…

Reviewed by: _______________________

LIGOCKI DENTAL GROUP

Oral Health Risk Factors

Patient's Name: ____

1. **Do you smoke or have you ever smoked? For how long?** ______________________ **Yes No**

   (If no proceed to question 2)

   The amount that you are presently smoking: (Check **ALL** that apply)

   ___None (quit smoking/chewing tobacco completely) Date you quit: ______________________________

   ___An occasional cigarette ___An occasional cigar

   ___A few cigarettes a day ___Cigars on a daily/regular basis

   ___ Less than 1 pack of cigarettes per day ___ Occasional pipe smoker

   ___1-2 packs of cigarettes per day ___ A pipe on a daily/regular basis

   ___2 or more packs of cigarettes per day ___Smokeless/chewing tobacco/snuff

2. **Approximate average amount of alcoholic beverages presently consumed per week:**

   ___None ___Less than 1 per week ___1-5 drinks ___6-11 drinks ___11-20 drinks ___ Over 20 drinks

3. **Do you have or have you had a substance abuse problem?** **Yes No**
4. **Do you presently use any recreational drugs: Type:** ________________________________ **Yes No**
5. **Do you have or have you ever had an eating disorder: Type:**__________________________ **Yes No**
6. **Do you have or have you ever had any head, neck or mouth piercing(s)? (Other than ears)** **Yes No**
7. **Do you have or have you ever been inform that you have been infected with an oncogenic strain (possible cancer-causing) of the Human Papilloma Virus (HPV)?** **Yes No**
8. **Other concerns and considerations:**

   ____

   ____

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, this practice will be informed of the changes without fail. I also consent to allow this practice to contact any healthcare provider(s) and to have the patient's health information released to aid in care and treatment. I also hereby consent to allow diagnosis, proper health care and treatment to be performed by this practice for the above named individual until further notice.
I understand there are no guarantees or warranties in health or dental care.

Signature: ____Date_______________________________

(Parent or guardian, if patient is a minor)

Continue on to the next page…

Reviewed by: _________________________

LIGOCKI DENTAL GROUP

DENTAL AND ORAL HEALTH INFORMATION

Patient's name: ____Date:____________________

Please describe any specific dental problem or discomfort you hare having at this time: __________________________

____

If you have had any of the following dental care, please list the dentists and approximate dates:

Periodontal (gum) treatment or surgery: ______________________________________ Date:_____________________

Braces or any type of orthodontic treatment: __________________________________ Date:_____________________

Dental Implants: ____ Date:_____________________

Any other type of oral surgery: ____Date:_____________________

Do you have/have you had/have you noticed any of the following signs or symptoms in your head, neck, or mouth?

(Please check Yes or No for each question)	**Yes**	**No**		**Yes**	**No**
Sensitivity to hot, cold, sweets, or biting pressure	___	___	Clicking, snapping or difficulty when chewing	___	___
An unpleasant taste or persistent bad breath	___	___	Difficulty opening or moving the jaws	___	___
Does food catch between your teeth	___	___	Difficulty speaking or changes in your voice	___	___
Red, swollen, tender, bleeding gums	___	___	Difficulty moving your tongue or tongue tied	___	___
Gums that have pulled away from teeth	___	___	Loose or separating teeth	___	___
Pus between the teeth and gums	___	___	Changes in the way your teeth fit together	___	___
Avoid any area when brushing or chewing	___	___	A color change of the tissues in your mouth	___	___
You clench or grind your teeth	___	___	Pain tenderness, numbness, or earaches	___	___
Sores, ulcers, or rough spots in your mouth	___	___	Any lumps, swelling or swollen glands	___	___

Your Dental Health:

How do you rate your overall dental health? ___Good ___Fair ___Poor

How many times a day do you brush your teeth? ____ How many times a week do you floss your teeth? _____

Do you use any of the following? (Please check Yes or No for each question)	**Yes**	**No**
Mechanical (electric) toothbrush If Yes, what type or brand? ____________________________________	___	___
Flossing aids (floss holders, threaders, etc.) ____	___	___
Oral irrigating device (Waterpik)	___	___
Fluoride treatments or supplements at home. If yes, which ones: __________________________________	___	___
Mouthwashes or oral rinses. If Yes, what brand? ____	___	___
Do you have any missing teeth that have not been replaced?	___	___
Why have you not had them replaced? ____		
Do you wear any removable dental appliances?	___	___
If yes, what type and for how long? ____		
Have you ever had your teeth whitened or bleached?	___	___
Would you like to have your teeth whitened or bleached?	___	___
How do you feel about the appearance of your smile and what would you change if you could?		
____		
Are you concerned about the finances required to return your mouth to excellent health?	___	___
Are you frustrated because you always need something treated or repaired when you visit a dentist?	___	___
Do you feel you will eventually wear artificial dentures?	___	___
Have you ever had any complications from an extraction or dental treatment?	___	___
If Yes, please explain: ____		
Have you ever had any other dental conditions, major trauma or injury to your head, neck, or mouth?	___	___
If yes, Please explain: ____		

Reviewed By: ____________________