

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 any 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 FOR AN EMERGENCY

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Email: _____

MEDICAL INSURANCE

Insurance Company: _____ Policy #: _____ Group #: _____

Subscriber's Name: _____ Relationship: _____

DOB: _____ Subscriber's SSN: _____ Employer: _____

DENTAL INSURANCE

Insurance Company: _____ Policy #: _____ Eff. Date: _____

Insured Name: _____ Relationship: _____

DOB: _____ SSN: _____ Employer: _____

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? _____

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
 Lactose (Milk Products) Y N
 Nuts 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
 Chemotherapy 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
 Partials/Full Dentures? Y N
 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

PATIENT NAME: _____

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)