Polaski Dental Group, PLLC

(845) 246-3070 v 8 Ulster Avenue v Saugerties, NY 12477

Patient Information Form

Welcome to Polaski Dental Group! To assist us with your healthcare, dental health, and general well being please complete the following confidential form. The information provided is important to your dental health. The best dental health care is based on a friendly, mutual understanding between the doctor and patient.

Today's date: __________________

Personal Information

Patient's name: __________________________ Preferred name: ____________ Birth date: __________

If a minor, parent or legal guardian: ____

Mailing address: _________________________ City: __________________ State: _____ ZIP: _______

Home phone: ____________________ Work: ____________________ Cell: ______________________

E-mail address: ____________________________ Referred by: ________________________________

Employer: ________________________________ Position: ____________________ How long? ______

Business address: ____

Marital status: _______ Spouse's name: ____________________ Spouse's employer: ______________

In case of emergency, please notify: __________________________ Phone: ______________________

Medical doctor: __________________________________ Doctor's phone: _______________________

Billing Information

Person financially responsible for this account: ____________________________ Relation: ___________

Billing address: ___________________________ City: __________________ State: _____ ZIP: _______

Patient's SS#: ____________________________ Insured's SS#: ________________________________

Primary dental insurance: ___________________ ID#: _____________________ Group #: __________

Secondary dental insurance: _________________ ID#: _____________________ Group #: __________

Payment method if not covered by dental insurance:

___ Cash ___ Check

___ Credit or debit card: _____________________________________ Exp. date: ___________

________ (initials) I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any services. Payment for dental treatment is due upon request.

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Medical History

Reason for today's visit: ___ Exam ___ Cleaning ___ Emergency ___ Consultation

___ Other: ________________________________ Are you in pain? ____ If yes, how long? ______

Please indicate any of the following problems with a check:

___ Discomfort, clicking, or popping in jaw
___ Red, swollen, or bleeding gums
___ Sensitive tooth, teeth, or gums
___ Blisters or sores in or around mouth
___ Lost or broken fillings
___ Teeth grinding
___ Ringing in ears
___ Broken or chipped tooth
___ Stained teeth
___ Locking jaw (TMJ/TMD)
___ Bad breath
___ Psychiatric problems
___ Other: ___________________

Do you require pre-medication? ___ Yes ___ No ___ Don't know

Previous dentist: ______________________________________ Phone: ____________________________

Last dental exam: ___________ Last dental x-rays: __________

Times a day you brush?___ Times a week you floss?____ Toothbrush bristle type: __Soft __Med __Hard

Do you use tobacco in any form? _______ If yes, what and how much? ____________________________

Are you under the care of a physician? ____ If yes, state condition: _______________________________

Are you pregnant? ______ If yes, expected delivery date: ______________________________

Do you have or have you had any of the following:

___ Heart ailment ___________________
___ Heart murmur
___ Artificial heart valves, date: ________
___ History of infective endocarditis
___ Congenital heart defect
___ Un-repaired congenital heart condition
___ Cardiac transplant problem in a heart valve
___ Angina
___ Tuberculosis, emphysema, or sarcoidosis
___ Lyme Disease
___ Migraines
___ Abnormal bleeding after extractions, surgery, or trauma
___ Artificial joints, such as hips or knees, date: ______
___ Blood pressure: High ____ or Low ____
___ Pacemaker, date: _______
___ Cancer or tumors (benign and/or malignant)
___ Kidney disease
___ Hepatitis
___ Gastrointestinal problems or ulcers
___ Substance abusive issues
___ Diabetes
___ Glaucoma
___ Epilepsy, seizures, or fainting spells
___ Depression or anxiety
___ Arthritis
___ Herpes or cold sores
___ AIDS or HIV positive
___ Anemia or blood disorders
___ Sinus problems
___ Allergies or hives
___ Asthma

Please list any medications you are currently taking: ____

____

Do you have any reactions or allergies to the following:

___ Aspirin
___ Penicillin or other antibiotics
___ Codeine or other narcotics
___ Local anesthetics ("Novocaine")
___ Sedatives
___ Latex materials
___ Foods: ___________________
___ Other: ___________________

List any other additional information you feel is important: ______________________________________

____

Signature of patient or guardian: _____________________________________ Date: ______________

Signature of doctor or hygienist: ______________________________________ Date: _______________