Zemencik Family Dental

528 Washington Ave Bridgeville, PA 15017

Patient Information

Name _____
Last First Middle Initial

Address _____
Street (Apt Number)

_____
City State Zip

Employer_____ Drivers License _____

Birthdate _____ Social Security # _____

Phone: HOME _____

MOBILE _____

WORK _____

Emergency Contact: _____ Phone: _____

Insurance

Subscriber Name _____ SS#_____DOB_____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to Patient _____

Insurance Authorization Statement (Sign & Date)

I hereby authorize payment of insurance benefits to Dr. Zemencik. I understand that I am responsible for all costs incurred with my dental treatment. I hereby authorize Dr. Zemencik to administer any medications and perform any diagnostic and therapeutic procedures necessary for my dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signature:_____ Date _____

Medical History:

Are you now or have you recently been under a physician's care? ___YES ___NO
Reason: _____
Have you ever had any surgery/operations? ___ YES ___NO
Explain: _____

Check any conditions below that you currently have or for which you have been treated:

___Anemia
___Asthma or Hay Fever
___Artificial Joints
___Arthritis
___Artificial Valves
___Blood Transfusion
___Cancer/Chemotherapy/Radiation
___Congenital Heart Defect
___Diabetes/Tuberculosis (TB)
___Difficult Extractions
___Difficulty Breathing
___Drug/Alcohol Abuse
___Emphysema
___Epilepsy/Seizures/Fainting
___Fever Blisters/Herpes
___Glaucoma
___Head/Neck /Jaw Injuries
___Heart Attack/Stroke
___Heart Murmur
___Heart Surgery/Pacemaker
___Hemophilia/Abnormal Bleeding
___Hepatitis/Liver Problems
___High/Low Blood Pressure
___HIV+/ AIDS
___Kidney Problems
___Mitral Valve Prolapse
___Psychiatric Problems
___Rheumatic/Scarlet Fever
___Severe/Frequent Headaches
___Sexually Transmitted Diseases
___Shingles
___Sinus Problems
___Temporal Mandibular Joint Problems
___Thyroid
___Ulcers/Colitis
___Venereal Disease

Check any of the following that you are currently taking or have recently taken:

___Anticoagulants/Blood Thinners
___Hormone Therapy
___Steroids
___Birth Control Pills, Shots or Implants
___Cortisone Drugs
___Sedatives/Tranquilizers

Are you currently taking any other medications and/or supplements? Please list:

_____

Are you allergic to or do you suffer ill effects from any of the following?

___Aspirin
___Penicillin
___Other Medications/Foods/Substances
___Codeine
___Dental Anesthesia
___Latex

Please list:_____

Woman only: Are you pregnant? ___YES ___NO. If yes, how many months? _____
Are you breast feeding? ___YES ___NO.

Reason for Today's visit:_____

Chief Dental Complaints/Problems/Sensitivity:_____

Date of Last Dental Appointment & Treatment Provided:_____

Signature:_____ Date: _____