Thank you for choosing the office of

Mark Niemiec, DDS

PATIENT NAME _____ **ID #** _____
Birthdate _____ SS# _____
Mailing Address _____ City _____ Zip _____
Physical Address _____ City _____ Zip _____
Phone number _____(h) _____ (w) _____(cell)

If Student: Name of School or College _____
Patient or Parent's Employer _____ Wk phone _____
Business Address _____ City _____ Zip _____
Spouse/Parent's Name _____ Employer _____ Wk #_____
Person to contact in case of emergency _____ phone _____

Whom may we thank for referring you? _____

RESPONSIBLE PARTY relationship to
Name of responsible party for this account _____patient _____
Address _____ Home phone _____
Driver's License # _____ Birthdate _____
Employer _____ Wk phone _____ SS# _____
Is this Person currently a patient in our office? ___ yes ___ no

For your convenience, we offer the following methods of payment. Payment in full is required at each appointment. ___ Cash ___ Check ___ Credit Cards
_____ **I** am interested in financing options

INSURANCE INFORMATION Relationship to
Name of Insured _____ Patient _____
Birthdate _____ SS# _____ Date Employed _____
Name of Employer _____ Wk phone _____
Address of Employer _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Policy # _____
Ins. Co. Address _____ City _____ State _____ Zip _____
How much is your deductible? _____ Annual Max _____ Used? _____

DO YOU HAVE ADDITIONAL INSURANCE? If yes, please complete the following

Relationship to
Name of Insured _____ Patient _____
Birthdate _____ SS# _____ Date Employed _____
Name of Employer _____ Wk phone _____
Address of of Employer _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Policy # _____
Ins. Co. Address _____ City _____ State _____ Zip _____
How much is your deductible? _____ Annual Max _____ Used? _____

OVER PLEASE

DENTAL/MEDICAL HISTORY INFORMATION

1. Do you have a toothache now or another dental complaint? . . . . . YES NO
2. Have you received medical treatment in the past 2 years? . . . . . .YES NO
3. Have you ever been hospitalized? . . . . . .YESNO
4. Have you taken any medication in the last 2 months? . . . . . YES NO
5. Are you allergic to or made sick by any medicine (ie. Penicillin, Aspirin, Codeine, etc.)? . . . . . .YES NO
6. Do you have chest pain? . . . . . .YES NO
7. Do you or does anyone in your family have diabetes? . . . . . .YES NO
8. Have you ever had a bleeding problem that required medical attention? . . . . .YES NO
9. Do you have any reason to believe you have been exposed to or have HIV or AIDS? . . . . . .YES NO
10. Have you ever had a sexually transmitted disease? . . . . . YES NO
11. Have you ever had any nervous or mental problems? . . . . . .YES NO
12. Do you smoke? . . . . . .YES NO
13. Do you drink alcoholic beverages? . . . . . .YES NO
14. Have you ever had any problems with local anesthetics (ie. Novocaine)?. . . . YES NO
15. Are you allergic to latex or do you have any types of allergies or hay fever? . .YES NO
16. Please list any medications (drugs or pills) you are currently taking:

_____

HAVE YOU EVER HAD THE FOLLOWING:

17. Hepatitis or jaundice	YES	NO	27. Epilepsy/seizures	YES	NO
18. Heart murmur	YES	NO	28. Arthritis/rheumatism	YES	NO
19. Rheumatic Fever	YES	NO	29. Blood transfusions	YES	NO
20. Heart attack	YES	NO	30. Kidney problems	YES	NO
21. High blood pressure	YES	NO	31. Injury to face or jaws	YES	NO
22. Heart valve or pace maker	YES	NO	32. Eye or ear problems	YES	NO
23. Artificial joint	YES	NO	33. Asthma	YES	NO
24. Chemotherapy or radiation	YES	NO	34. Sinus problems	YES	NO
25. Cancer or tumors	YES	NO	35. Ulcers	YES	NO
26. Stroke	YES	NO	36. TB or lung disease	YES	NO

37. Do you or have you had any disease, condition, or problem not listed above? YES NO
38. Do you have any concerns about receiving dental treatment? YES NO

FEMALES ONLY: Are you:

1. Pregnant? YES NO 2. Taking birth control pills? YES NO 3. Nursing? YES NO

NOTES: (Dental Staff) _____

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_I certify that I have read and understood the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to use my information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient/Parent/ Guardian _____ Date _____

Dentist _____ Date _____

Physician's Name:_____ Preferred Pharmacy:_____