Michael Gadeken, D.D.S., P.C.

DATE_____ 1 2 3 4 5 6 7

Confidential Patient Information

Patient's Name_____ Name you wish to be called_____
Last First M.I.

Address_____
Street City State Zip

Home Phone_____ Birthdate_____ Social Security #_____-_____-_____

If patient is a minor, give parent or guardian's name_____

Email Address_____

Confidential Responsible Party Account Information

Name_____ Marital Status_____
Last First Middle

Residence_____
Street City State Zip

Mailing Address_____
Street City State Zip

How long at this address_____ Phone H_____ W_____ C_____

Email Address_____

Whom may we thank for referring you to our office?_____

Previous Address (if less than 3 yrs.)_____
Street City State Zip

Social Security #_____-_____-_____ Birthdate_____ Relationship to Patient_____

Employer_____ Occupation_____ No. Years Employed_____

Spouse's Name_____ Relationship to Patient_____
Last First M.I.

Employer_____ Occupation_____ No. Years Employed_____

Social Security #_____-_____-_____ Birthdate_____ Work Phone_____

Dental Insurance Information

Policy Holder's Name_____ Employee or Soc. Sec. #_____

Insurance Company_____ Group No._____ Union Local No._____

Insurance Co. Address_____ Insurance Co. Phone_____

Policy Holder's Employer_____

If you have dual coverage fill our secondary dental information below

Policy Holder's Name_____ Employee or Soc. Sec #_____

Insurance Company_____ Group No._____ Union Local No._____

Insurance Co. Address_____ Insurance Co. Phone_____

Policy Holder's Employer_____

Emergency Information

Name of nearest relative not living with you_____

Address_____ Phone_____ Relationship_____

Medical and Dental Information

Medical History

The use of drugs in modern dentistry requires a current, pertinent medical history for your protection.
Please circle and give approximate dates if you have had any of the following:

None
Endocarditis
Valve Replacement
Heart Murmur
Pacemaker
Joints Replaced
Hepatitis
Tuberculosis
HIV/AIDS
High/Low Blood Pressure
Excess Bleeding
Bruise Easily
Blood Disorders
Chest Pains
Heart Surgery
Other Surgery
Stomach Disorder
Liver Disease
Kidney Disease
Tobacco User
Hearing Problems
Vision Problems
Arthritis
Hay Fever/Asthma
Sinus Problems
Shortness of Breath
Diabetes
Epilepsy
Periodontal/Gum Disease
Cancer
Stroke
Pregnant
Fainting Spells
Psychiatric Treatment
*Allergy/Food
*Allergies to Metals
(list)_____
_____
*Allergy Drug (list)
Penicillin
Sulpha Drugs
Novocain
OTHER_____

Other Conditions/Explain_____

_____

Have you been hospitalized in the past 3 years?_____Why?_____

Current Medications_____

Physician_____Phone_____

Dental History

Specific dental need today

_____

We hope to make your visit with us a pleasant one. Please let us know if you have any fears of dentistry. If so, please describe what made you fearful._____

_____

Is there anything we can do to make your visit more comfortable? *i.e.: Nitrous Oxide, Headphones, Neck Pillow, Blanket*

_____

THANK YOU FOR CHOOSING OUR OFFICE FOR YOUR DENTAL NEEDS!

We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us We will be happy to help.

I understand that where appropriate, credit bureau reports may be obtained.
In the event of non-payment, additional collection costs and/or attorney fees will be added to the unpaid balance.

Patient Signature_____Date_____
(Parent's signature if minor)

CONFIDENTIAL (For record and pretreatment evaluation)