NEW PATIENT WELCOME PACKET

Welcome and thank you for selecting Marian C. Pilecki, DDS and her dental health care team. We strive to provide our patients with the best possible dental care. To help us meet all of your dental needs, please fill out this form completely. If you have any questions or need assistance, please ask us. We will be happy to help.

PATIENT INFORMATION

NAME_____DATE_____

GENDER: ☐ MALE ☐ FEMALE

STATUS ☐ MINOR ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED ☐ SINGLE

PREFERRED NAME:_____ SPOUSE'S NAME:_____

BIRTHDATE:_____ SOC. SEC. # _____

ADDRESS_____

CITY_____ STATE_____ZIP_____

PHONE: HOME_____WORK_____CELL_____

EMPLOYER_____ OCCUPATION_____

REFERRED BY_____

RESPONSIBLE PARTY INFORMATION

NAME_____

BIRTH DATE_____DRIVERS LIC #_____ SOC. SEC.#_____

ADDRESS_____

CITY_____ STATE_____ZIP_____

EMPLOYER_____ OCCUPATION_____

HOME PHONE_____ WORK PHONE_____

CELL PHONE_____ PREFER CALLS ☐ HOME ☐ WORK ☐ CELL

IN CASE OF EMERGENCY

CONTACT NAME _____ RELATIONSHIP _____

HOME PHONE_____ CELL PHONE_____WORK PHONE_____EXT__

OFFICE POLICIES

Thank you for choosing Marian C. Pilecki, DDS for your dental care needs. We believe it's important to share our policies with our patients in advance. As always, we are pleased to answer any questions you may have or explain the treatment process in greater detail. Please read thoroughly and sign below indicating that you understand these policies and agree to comply with them. We welcome your questions and comments and are committed to providing excellent dental care services to all our patients. We appreciate the confidence you place in us.

- **Insurance**

We may accept assignment of insurance benefits from your primary carrier after your second visit. Your co-insurance portion, including any deductible, is due at the time of service. Your co-payment is calculated on the information provided by your carrier at the time of estimate. Please note that your insurance policy is a contract between you and your insurance company; we are not a party to that contract. We accept assignment of benefits as a courtesy to our patients, any claim not paid by your insurance carrier within 60 days will be billed to the patient.

- **Missed Appointments**

Please help us serve you and our other patients better by keeping scheduled appointments. Our answering machine does not accept cancellations. We prefer to speak with you in person and require two (2) business days advance notice to reschedule appointments. There may be a charge at the rate of a normal office visit for missed appointments or cancellations made less than two day's notice.

- **Delinquent Accounts**

In the event payments are not received by agreed upon dates, a 1.75% late charge (21%APR) may be added to the delinquent account, Attorney's fees and collection fee's incurred to settle any outstanding balance are the responsibility of the patient. There will be a $35.00 fee for any returned check.

METHODS OF PAYMENT

Payment for services is expected at the time of treatment unless prior arrangements have been made. For your convenience we accept: (please check your preferred option)

Cash ☐ **Check** ☐ **Credit Card**: ☐ Master Card ☐ Visa ☐ Discover ☐ AmEx

☐ Check here if you'd like to learn more about Care Credit (a no interest or low interest financing program)

_____ _____ _____

Signature of patient or Parent/Guardian of a minor | Signature of Co-responsible Party | Date

Print Name_____

MEDICAL HISTORY

Are you under a physician's care now? ☐ YES ☐ NO If yes_____

Have you ever been hospitalized or had a major operation? ☐ YES ☐ NO

If yes_____

Have you ever had a serious head or neck injury? ☐ YES ☐ NO If Yes _____

Are you taking any medications? ☐ YES ☐ NO If yes _____

_____

Did you take the drugs fen-Phen or Redux? ☐ YES ☐ NO If yes_____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ YES ☐ NO If yes _____

Do you use a CPAP machine? ☐ YES ☐ NO if yes _____

Do you wake up during the night? ☐ YES ☐ NO If yes _____

Do you find it difficult to concentrate? ☐ YES ☐ NO if yes _____

Do you have swollen, stiff or painful joints? ☐ YES ☐ NO If yes_____

Are you on a special Diet? ☐ YES ☐ NO If yes _____

Do you use tobacco? ☐ YES ☐ NO If yes _____

WOMEN: Are you….

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

ARE YOU ALLERGIC TO THE FOLLOWING?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics ☐ Other_____

Do you use controlled substances? ☐ YES ☐ NO If yes _____

Have you ever had a serious illness not listed? YES☐ NO☐ If yes_____

Average hours of sleep per night? _____

Do you have difficulty breathing while sleeping? YES☐ NO☐ _____

Have you ever had a sleep study? YES☐ NO☐ Results?_____

Do you experience any of the following?

Do you wake rested? ☐YES ☐NO

Easy to fall asleep? YES☐ NO☐

Take Medication to aid sleep? ☐ YES ☐ NO

Jaw Popping, Clicking, Pain? YES☐ NO☐

Do you wake with Headaches? ☐YES ☐ NO

Do you have facial Pain? YES☐ NO☐

How often do your headaches occur? ☐Daily ☐Weekly ☐Monthly?

Do you have any concerns with…

☐General appearance	☐ Teeth Crowding	☐ Smile
☐ Overbite	☐Teeth Grinding	☐Ability to function
☐Gum disease	☐TMJ	☐Facial pain
☐Sleep concerns	☐Missing teeth	☐ cavities

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

AIDS/HIV Positive	☐YES ☐ NO	Bruise easily	☐ YES ☐ NO
Alzheimer's disease	☐YES ☐ NO	Cancer	☐YES ☐ NO
Anaphylaxis	☐ YES ☐ NO	Chemotherapy	☐YES ☐ NO
Anemia	☐ YES ☐ NO	Chest Pains	☐YES ☐ NO
Angina	☐YES ☐ NO	Cold sores/Fever Blisters	☐YES ☐ NO
Arthritis/Gout	☐ YES ☐ NO	Congenital heart disorder	☐YES ☐ NO
Artificial heart valve	☐ YES ☐ NO	Convulsions	☐YES ☐ NO
Artificial Joint	☐YES ☐ NO	Yellow Jaundice	☐YES ☐ NO
Asthma	☐YES ☐ NO	Depression	☐YES ☐ NO
Blood Disease	☐YES ☐NO	Cortisone medicine	☐YES ☐ NO
Blood transfusion	☐YES ☐ NO	Diabetes	☐YES ☐ NO
Breathing problems	☐YES ☐ NO	Drug addiction	☐YES ☐ NO

Easily winded ☐ Yes ☐ NO

Emphysema ☐ YES ☐ NO

Epilepsy or seizures ☐ YES ☐ NO

Excessive bleeding ☐ YES ☐ NO

Excessive thirst ☐ YES ☐ NO

Fainting spells/dizziness ☐ YES ☐ NO

Frequent cough ☐ YES ☐ NO

Frequent diarrhea ☐ YES ☐ NO

Frequent headaches ☐ YES ☐ NO

Genital herpes ☐ YES ☐ NO

Glaucoma ☐ YES ☐ NO

Hay fever ☐ YES ☐ NO

Heart attack/failure ☐ YES ☐ NO

Heart Murmur ☐ YES ☐ NO

Heart pacemaker ☐ YES ☐ NO

Heart trouble/disease ☐ YES ☐ NO

Facial pain ☐ YES ☐ NO

Difficulty breathing ☐ YES ☐ NO

Hemophilia ☐ YES ☐ NO

Hepatitis A ☐ YES ☐ NO

Hepatitis B or C ☐ YES ☐ NO

Herpes ☐ YES ☐ NO

High blood pressure ☐ YES ☐ NO

High cholesterol ☐ YES ☐ NO

Hives or rash ☐ YES ☐ NO

Hypoglycemia ☐ YES ☐ NO

Irregular heart beat ☐ YES ☐ NO

Kidney problems ☐ YES ☐ NO

Leukemia ☐ YES ☐ NO

Liver disease ☐ YES ☐ NO

Low blood pressure ☐ YES ☐ NO

Lung disease ☐ YES ☐ NO

Mitral valve prolapse ☐ YES ☐ NO

Osteoporosis ☐ YES ☐ NO

Pain in jaw joints ☐ YES ☐ NO

Parathyroid disease ☐ YES ☐ NO

Psychiatric care ☐ YES ☐ NO

Snoring ☐ YES ☐ NO

Memory Loss ☐ YES ☐ NO

Radiation treatments ☐ YES ☐ NO

Recent weight loss ☐ YES ☐ NO

Renal dialysis ☐ YES ☐ NO

Rheumatic fever ☐ YES ☐ NO

Rheumatism ☐ YES ☐ NO

Scarlet fever ☐ YES ☐ NO

Shingles ☐ YES ☐ NO

Sickle cell disease ☐ YES ☐ NO

Sinus trouble ☐ YES ☐ NO

Spina bifida ☐ YES ☐ NO

Stomach/Intestinal disease ☐ YES ☐ NO

Stroke ☐ YES ☐ NO

Swelling of limbs ☐ YES ☐ NO

Thyroid disease ☐ YES ☐ NO

Tonsillitis ☐ YES ☐ NO

Tuberculosis ☐ YES ☐ NO

Tumors or growths ☐ YES ☐ NO

Ulcers ☐ YES ☐ NO

Venereal disease ☐ YES ☐ NO

Anxiety ☐ YES ☐ NO

Intestinal disorder ☐ YES ☐ NO

Cold hands/feet ☐ YES ☐ NO

Gasping or choking during sleep ☐ YES ☐ NO

GERD ☐ YES ☐ NO

Stop breathing during sleep? ☐ YES ☐ NO

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients) health. It is my responsibility to inform the dental office of any changes in medical status.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

*YOU MAY REFUSE TO SIGN THIS AKNOWLEGEMENT

I, _____ (please print name)

Have received a copy of this office's notice of privacy practices.

SIGNATURE: DATE:

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our notice of privacy practices, but acknowledgement could not be obtained because:

__ Individual refused to sign

__ Communication barriers prohibited obtaining the acknowledgement

__ An emergency situation prevented us from obtaining acknowledgement

__ Other (please specify)