Marian C. Pilecki, DDS
family-friendly dentistry

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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 your dental care 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

Please Print

Name: _____ Date: _____

Gender: ☐ Male ☐ Female Status: ☐ Minor ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Nickname: _____ Spouse's Name: _____

Birth Date: _____ Soc. Sec. #: _____

Address: _____

City: _____ State: _____Zip: _____

Employer: _____ Occupation: _____

Referred By: _____

RESPONSIBLE PARTY INFORMATION

Name: _____ Relationship to Patient: _____

Birth Date: _____ Driver's Lic. #: _____ Soc. Sec. #: _____

Address: _____

City: _____ State: _____Zip: _____

Employer: _____ Occupation: _____

Home Phone: _____ Work Phone: _____ Ext. _____

Cell Phone: _____ Prefer Calls: ☐ Home ☐ Work ☐ Cell

In Case of Emergency:

Contact Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Ext. _____

DENTAL INSURANCE INFORMATION

Primary Insurance: Policy Holder Information	Secondary Insurance: Policy Holder Information
Policy Holder Name: _____	Policy Holder Name: _____
Relationship to Patient: _____	Relationship to Patient: _____
Date of Birth: _____ Soc. Sec. #: _____	Date of Birth: _____ Soc. Sec. #: _____
Insurance Company: _____	Insurance Company: _____
Ins. Co. Address: _____	Ins. Co. Address: _____
Group #/Contract #: _____	Group #/Contract #: _____
Employee/Cert #: _____Deductible: $_____	Employee/Cert #: _____Deductible: $_____
Amount Used to Date: $_____ Max. Ann. Benefit: $_____	Amount Used to Date: $_____ Max. Ann. Benefit: $_____

AUTHORIZATION AND RELEASE

- I authorize the dentist to release any information, including the diagnosis and any record of treatment or examination, rendered to me or my child during the period of such dental care to third-party payers and/or other health practitioners.
- I authorize and request my insurance company to pay directly to the dentist any 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 the services rendered on my behalf or my dependents.
- I request and authorize the dental staff to perform necessary dental services for my child or dependent, including but not limited to, x-rays and administration of anesthetics that are deemed advisable by the doctor, whether or not I am present at the actual appointment when treatment is rendered.
- I give consent to the use of any dental photography for educational and/or promotional use.

_____ Signature of Patient or Parent/Guardian of Minor

_____ Signature of Co-Responsible Party

_____ Date

MEDICAL HISTORY

Although dentistry treats primarily the area in and around your mouth, your mouth is a part of your entire body. We believe in the importance of treating the patient holistically. Therefore, other health problems or medications that you may be taking could be relevant to your dental care. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No If YES, please explain: _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If YES, please explain: _____

_____

Have you ever had a serious head/neck injury? ☐ Yes ☐ No If YES, please explain: _____

Are you taking any medications, vitamins, pills or drugs? ☐ Yes ☐ No Please list: _____

_____

Do you take, or have you taken, Phen-Fan or Redux? ☐ Yes ☐ No _____

Are you on a special diet? ☐ Yes ☐ No _____

Do you use tobacco? ☐ Yes ☐ No

Do you use controlled substances? ☐ Yes ☐ No

Women

Are you pregnant or trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other, please explain: _____

Do you have, or have you had, any of the following (please check all that apply)?

☐ AIDS/HIV Positive	☐ Cortisone Medicine	☐ Hemophilia	☐ Renal Disease
☐ Alzheimer's Disease	☐ Diabetes	☐ Hepatitis A	☐ Rheumatic Fever
☐ Anaphylaxis	☐ Drug Addiction	☐ Hepatitis B or C	☐ Rheumatism
☐ Anemia	☐ Easily Winded	☐ Herpes	☐ Scarlet Fever
☐ Angina	☐ Emphysema	☐ High Blood Pressure	☐ Shingles
☐ Arthritis/Gout	☐ Epilepsy or Seizures	☐ Hives or Rash	☐ Sickle Cell Disease
☐ Artificial Heart Valve	☐ Excessive Bleeding	☐ Hypoglycemia	☐ Sinus Trouble
☐ Artificial Joint	☐ Excessive Thirst	☐ Irregular Heartbeat	☐ Spinal Bifida
☐ Asthma	☐ Fainting Spells/Dizziness	☐ Kidney Problems	☐ Stomach/Intestinal Disease
☐ Blood Disease	☐ Frequent Cough	☐ Leukemia	☐ Stroke
☐ Blood Transfusion	☐ Frequent Diarrhea	☐ Liver Disease	☐ Swelling of Limbs
☐ Breathing Problems	☐ Frequent Headaches	☐ Low Blood Pressure	☐ Thyroid Disease
☐ Bruise Easily	☐ Genital Herpes	☐ Lung Disease	☐ Tonsillitis
☐ Cancer	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Tuberculosis
☐ Chemotherapy	☐ Hay Fever	☐ Pain in Jaw Joints	☐ Ulcers
☐ Chest Pains	☐ Heart Attack/Failure	☐ Parathyroid Disease	☐ Venereal Disease
☐ Cold Sores/Fever Blisters	☐ Heart Murmur	☐ Psychiatric Care	☐ Yellow Jaundice
☐ Congenital Heart Disorder	☐ Heart Pace Maker	☐ Radiation Treatments	
☐ Convulsions	☐ Heart Trouble/Disease	☐ Recent Weight Loss	

Have you ever had a serious illness not listed above? ☐ Yes ☐ No If YES, please explain: _____

Comments: _____

_____

_____

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information may be dangerous to my (or the patient's) health. I understand that it is my responsibility to inform the dental office promptly of any changes in overall health or medical status.

Signature of Patient, Parent, or Guardian_____ Date: _____

DENTAL HISTORY

Reason for visit today? _____

Date of: Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

What was done at your last dental visit? _____

Previous Dentist's Name: _____ Phone: _____

Address: _____

How often do you have dental examinations? _____ How often do you brush your teeth? _____

How often do you floss? _____ What dental aids do you use? (Proxybrush, rinses, etc.) _____

Are any of your teeth sensitive to:	
Hot or cold?	☐ Yes ☐ No
Sweets?	☐ Yes ☐ No
Biting or chewing?	☐ Yes ☐ No
Do you notice any mouth odor or bad taste?	☐ Yes ☐ No
Do you frequently get cold sores, blisters or any other oral lesions?	☐ Yes ☐ No
Do your gums bleed or hurt?	☐ Yes ☐ No
Have your parents experienced gum disease or tooth loss?	☐ Yes ☐ No
Have you noticed any loose teeth or change in your bite?	☐ Yes ☐ No
Does food tend to become caught in your teeth? If yes, where _____	☐ Yes ☐ No
Do you:	
Clench or grind your teeth while awake?	☐ Yes ☐ No
Clench or grind your teeth while you sleep?	☐ Yes ☐ No
Bite your lips or cheeks regularly?	☐ Yes ☐ No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	☐ Yes ☐ No
Mouth breathe while awake or asleep?	☐ Yes ☐ No
Have tired jaws, especially in the morning?	☐ Yes ☐ No

Have you ever had:	
Orthodontic treatment?	☐ Yes ☐ No
Oral surgery?	☐ Yes ☐ No
Periodontal treatment?	☐ Yes ☐ No
Your teeth ground or the bite adjusted?	☐ Yes ☐ No
A bite plate or mouth guard?	☐ Yes ☐ No
A serious injury to the mouth?	☐ Yes ☐ No
If yes, describe_____	
Have you ever experienced:	
Clicking or popping of the jaw?	☐ Yes ☐ No
Joint, ear or side of face pain?	☐ Yes ☐ No
Difficulty in closing mouth?	☐ Yes ☐ No
Headaches, neck aches or shoulder aches?	☐ Yes ☐ No
Sore muscles? (neck or shoulders)	☐ Yes ☐ No
Are you satisfied with your teeth's appearance?	☐ Yes ☐ No
Would you like to keep all of your teeth, all of your life?	☐ Yes ☐ No
Do you feel nervous about having dental treatment?	☐ Yes ☐ No
If so, what is your biggest concern? _____	
Have you ever had an upsetting dental experience?	☐ Yes ☐ No
If so, please describe _____	

Is there anything else about having dental treatment that you would like us to know? _____

_____

_____

FOR OFFICE USE ONLY

Reviewed by: _____ Date: _____

(staff signature)

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-insurance or 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 advanced notice to reschedule appointments. There may be a charge at the rate of a normal office visit for missed appointments or cancellations made on less than two days 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 fees incurred to settle any outstanding balance are the responsibility of the patient. There will be a $25.00 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 you convenience we accept: (please check your preferred option)

☐ Cash ☐ Check Credit Card: ☐ MasterCard ☐ Visa ☐ Discover ☐ AmEx

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

_____	_____	_____
Signature of Patient or Parent/Guardian of Minor	Signature of Co-Responsible Party	Date

*Fees subject to change without notice.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

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)

_____
_____
_____