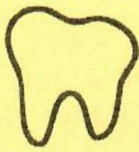

SELASKY FAMILY DENTISTRY

Patient Information

Patients under the age of 18 cannot be treated unless accompanied by a parent or legal guardian.

Name	Preferred name	Home Phone	Cell Phone
Address		City	State, Zip
Email address		Occupation	Work Phone
Employer	Employer's Address		
Social Security #	Date of Birth		Marital Status
Emergency Contact	Phone Number		Relationship to patient
Previous Dentist	Address		Phone Number
Reason for changing Dentist			
Person Responsible for account		Relationship to patient	
Address:		City	State, Zip
Social Security #		Date of Birth	
Employer	Employer's Address		

Primary Insurance Information		**Secondary Insurance Information**	
Employee Name		Employee Name	
Social Security #	Date of Birth	Social Security #	Date of Birth
Name and address of Insurance Company		Name and address of Insurance Company	
Employer		Employer	
Group #		Group #	

I hereby authorize payment directly to Jeffrey Selasky, DDS, of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment upon receipt of dental treatment.

X Signed:______________________________ Date:______________

(Patient or Parent if patient is a minor.)

Medical History

Patient's Name ______________________________

Name of Physician ______________________ Phone ______________ Fax# ______________

Date/purpose of last visit ______________________________

What is your estimate of your general health? □Excellent □Good □Fair □Poor

Have you ever been hospitalized or had a major operation? □ Yes □ No If yes, please explain: ______________

Have you ever had a serious head or neck injury? □Yes □No If yes, please explain: ______________

Are you on a special diet? □Yes □No

Do you or have you ever used tobacco? □Yes □No Do you use controlled substances? □Yes □No

Are you currently taking any medications, pills, or drugs? □Yes □No If yes please explain: ______________

Women: Are you:

Pregnant/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 □ Latex □ Local Anesthetics □ Erythromycin □ Tetracycline □ Flouride

□ Metals (gold, stainless steel) □ Other If yes, please explain: ______________

Have you (or your dependent child) ever had any of the following?

AIDS/HIV positive	□Yes □No	Difficulty swallowing	□Yes □No	Low blood pressure	□Yes □No
Alcohol/Drug Dependency	□Yes □No	Emphysema	□Yes □No	Lung disease	□Yes □No
Alzheimer's Disease	□Yes □No	Epilepsy/convulsions (seizures)	□Yes □No	Mitral valve prolapse	□Yes □No
Anemia or blood disorder	□Yes □No	Excessive thirst	□Yes □No	Night sweats	□Yes □No
Angina	□Yes □No	Frequent headaches	□Yes □No	Osteoporosis/osteopenia (taking bisphosphonates)	□Yes □No
Any lumps or swelling In the mouth	□Yes □No	Glaucoma	□Yes □No		
		Hay Fever	□Yes □No	Prolonged bleeding due to a slight cut	□Yes □No
Artificial Heart valve	□Yes □No	Heart attack/failure	□Yes □No		
Artificial Joint	□Yes □No	Heart problems/disease	□Yes □No	Radiation treatment	□Yes □No
Arthritis	□Yes □No	Heart murmur	□Yes □No	Renal dialysis	□Yes □No
Bleeding disorder	□Yes □No	Heart pacemaker	□Yes □No	Rheumatic fever	□Yes □No
Blood transfusion	□Yes □No	Hemophilia	□Yes □No	Rheumatism	□Yes □No
Breathing or sleeping problems (snoring, sinus, sleep apnea)	□Yes □No	Hepatitis (type_____)	□Yes □No	Scarlet fever	□Yes □No
		High Blood pressure	□Yes □No	Sickle Cell Disease	□Yes □No
Cancer	□Yes □No	High cholesterol	□Yes □No	Sinus trouble	□Yes □No
Chemotherapy	□Yes □No	Hives, rash, hay fever	□Yes □No	Stroke	□Yes □No
Chest Pains	□Yes □No	HPV (human papilloma virus)	□Yes □No	Thyroid or parathyroid disease	□Yes □No
Cold sores/fever blisters	□Yes □No	Hypoglycemia	□Yes □No	Tonsillitis	□Yes □No
Congenital heart disorder	□Yes □No	Intestinal/stomach disorder	□Yes □No	Tuberculosis	□Yes □No
Cortisone medication	□Yes □No	Kidney disease	□Yes □No	Tumor, abnormal growth	□Yes □No
Diabetes	□Yes □No	Leukemia	□Yes □No	Ulcers	□Yes □No
Digestive disorders (ie gastric reflux)	□Yes □ No	Liver disease	□Yes □No		

Please list any serious illness not listed above, current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment. ______________________________

I certify that the answers given to the preceding questions are correct to the best of my knowledge.

Signature ______________________________ Date: ______________

Authority To Proceed

I hereby grant Dr. Jeffrey Selasky to administer any treatment, to administer such anesthetics, and to perform such procedures as may be deemed necessary in the diagnosis and treatment of my case. I acknowledge that I will be informed of the risks and possible consequences of the treatment proposed and do authorize Dr. Jeffrey Selasky to proceed.

Signature: ______________________________ Date: ______________