MICHAEL R. DOROCIAK, D.D.S.

Family & Cosmetic Dentistry

Confidential Patient Information – Part I

(Please Print Legibly)

Date: _____

PERSONAL INFORMATION

Name: _____ SS #: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (Home) _____ (Work) _____

(Cell) _____ E-mail: _____

Birth Date: _____ Sex: _____ Marital Status: _____ Spouse Name: _____

Occupation: _____ Referred by: _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relationship: _____ SS #: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (Home) _____ (Work) _____

DENTAL INSURANCE INFORMATION

Primary Insurance Co: _____

Insurance Co. Address: _____

Employee: _____ Relationship: _____

S.S. #: _____ Date of Birth: _____

Employer: _____ Policy #: _____

Secondary Insurance Co: _____

Insurance Co. Address: _____

Employee: _____ Relationship: _____

S.S. #: _____ Date of Birth: _____

Employer: _____ Policy #: _____

I understand that payment is my obligation regardless of insurance or any other third-party involvement.

CONSENT: I consent to the diagnostic procedures and treatments by Dr. Michael R. Dorociak and his staff for necessary proper dental care.

Signature: _____ Date: _____

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Confidential Patient Information – Part II

(Please Print Legibly)

Patient Name: _____ Initial Date: _____

Updated: _____

Updated: _____

Updated: _____

Updated: _____

HEALTH INFORMATION

Personal Physician Name: _____

Personal Physician Address: _____

YES	NO		
❑	❑	1.	Have you been hospitalized within the past 2 years? For what? _____
❑	❑	2.	Are you currently being treated by a physician? For what? _____
❑	❑	3.	Are you currently taking any medicines or drugs? What? _____
❑	❑		_____
❑	❑	4.	Have you ever received counseling for excessive use of alcohol and/or prescription drugs?
❑	❑	5.	Are you allergic to any drugs? What? _____
❑	❑	6.	Have you ever had a skin rash or other reaction to metal jewelry? To What? _____
❑	❑	7.	Are you allergic to any metals? What? _____
❑	❑	8.	Do you bleed excessively upon injury?
❑	❑	9.	Are you pregnant?
❑	❑	10.	Have you ever been involved with dental/medical legal activity?

CIRCLE ANY OF THE FOLLOWING CONDITIONS THAT YOU HAVE HAD OR NOW HAVE

A. AIDS
B. Arthritis
C. Asthma
D. Cancer
E. Diabetes
F. Epilepsy
G. Glaucoma
H. Heart Murmur
I. Heart Problem*
J. Hepatitis
K. High Blood Pressure
L. Jaundice
M. Kidney Problems
N. Low Blood Pressure
O. Nervous Breakdown or Psychiatric Therapy
P. Rheumatic Fever
Q. Joint Replacement
R. Sexually Transmitted Diseases
S. Stroke
T. Tuberculosis
U. Other Diseases*

**If you circled either I or U describe condition:* _____

PERSON TO BE CONTACTED IN CASE OF EMERGENCY

Name: _____

Address: _____

Telephone: (Home) _____ (Work) _____

Signature: _____ Reviewed By: _____ Date: _____

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Dental History

How may we help you today? _____

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

Do you require antibiotics before dental treatment? ❑ Yes ❑ No

Are you currently in pain? ❑ Yes ❑ No

Have you ever had gum treatment? ❑ Yes ❑ No

Do you now or have you had any pain/discomfort in your jaw joint? (TMJ) ❑ Yes ❑ No

Are you under stress? (new job,moving,relationships) ❑ Yes ❑ No

Do you like your smile? ❑ Yes ❑ No

Is there anything you would like to change about your smile? ❑ Yes ❑ No

Are you happy with the color of your teeth? ❑ Yes ❑ No

Do your gums bleed? ❑ Yes ❑ No

How many times a do you: floss/week?_____ brush/day?_____

Are your teeth sensitive to hot, cold or anything else? ❑ Yes ❑ No

Have you lost any teeth? ❑ Yes ❑ No

Have you ever had a serious/difficult problem with any previous dental work? ❑ Yes ❑ No

Have you ever had any unfavorable dental experiences? ❑ Yes ❑ No

When was your last dental cleaning? _____

When was your last dental visit? _____

Why did you leave your previous dentist? _____

How can we accommodate you better during your dental visit?_____

Here at Dr. Michael R. Dorociak's office we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below you would like our friendly staff to discuss with you during your visit.

Sapphire Tooth Whitening	Veneers/Lumineers	Invisalign
Traditional Orthodontics (Brackets)	Smile Makeover	Bonding
Sealants	Crown and Bridge	Implant Crowns
Partials/Dentures	Night/Sport Guards	