Robert L. Malecki, D.D.S., P.C.

Patient Information

989-892-7663

Name _____ Date _____
First MI Last

Address _____ City _____ State _____ Zip _____

E-mail _____ Cell Phone _____ Home Phone _____

SS# _____ Birthdate _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If College Student, F.T. / P.T., Name of School _____ City _____ State _____

Patient's Employer _____ Work phone _____

Employer's Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of an emergency _____ Phone _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone # _____ Relationship to Patient _____

Responsible Party Information

Name _____ Marital Status _____
First MI Last

Residence _____
Number, Street City State Zip

Billing Address (if different) _____

How long at this address? _____ Birthdate _____ Social Security # _____

Driver's License # _____ Relationship to Patient _____

Home Phone _____ Cell Phone _____

Employer _____ Occupation _____ # Years Employed _____

Employer Address _____ Work Phone _____

Responsible Party Spouse

Name _____ Social Security # _____
First MI Last

Cell Phone _____ Birthdate _____

Employer _____ # Years Employed _____

Employer Address _____ Employer Phone _____

Primary Dental Insurance

Insured's Name _____ Insured's S.S.# _____

Insurance Company _____ ID # _____ Group # _____

Address to mail claim to _____

Insurance Phone Number _____ Insured's Employer _____

Do you have any additional insurance? ☐ Yes ☐ No If yes, complete the following

Secondary Dental Insurance

Insured's Name _____ Insured's S.S.# _____

Insurance Company _____ ID # _____ Group # _____

Address to mail claim to _____

Insurance Phone Number _____ Insured's Employer _____

Dental History

Patient's Name _____ **Date of Birth** _____

How often do you brush your teeth _____ How often do you floss your teeth _____

	Yes	No
Do your gums bleed while brushing or flossing?	☐	☐
Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
Do you smoke or use tobacco products in any form?	☐	☐
How much_____How long_____		
Do you now or have you used controlled substances in the past?	☐	☐
Are you having any pain or discomfort at this time?	☐	☐
Do you avoid brushing any part of your mouth because of pain?	☐	☐
Does food catch between your teeth?	☐	☐
Do you have difficulty in chewing your food?	☐	☐
Do you chew on one side of your mouth?	☐	☐
Have you ever taken Fosamax, Boniva, Actonel or any medications containing Bisphosphonates?	☐	☐
Have you ever experienced abnormal bleeding?	☐	☐
Do you have a persistent cough or throat clearing, not associated with a known illness (lasting more than 3 weeks) or any changes to your voice?	☐	☐
Do you gag easily?	☐	☐
Have you ever been treated for periodontal disease? When _____	☐	☐
Do you have any family history of gum disease?	☐	☐
Have you ever had any orthodontic treatment?	☐	☐
Have you ever had any type of trauma to your mouth, jaw or face?	☐	☐
If yes, describe:		
Do you wear dentures or partials? If so, date of placement:_____	☐	☐
Do you have any concerns about		
Unpleasant taste	☐	☐
Burning tongue / lips	☐	☐
Frequent blisters, lips / mouth	☐	☐
Do you have any sores or lumps in or near your mouth?	☐	☐
Do you have any jaw symptoms or headaches upon awakening in the morning?	☐	☐
Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities?	☐	☐
Have you ever experienced any other following problems in your jaw?		
Clicking	☐	☐
Pain (Joint, Ear, Side of Face)	☐	☐
Difficulty in Opening or Closing	☐	☐
Difficulty in Chewing	☐	☐
Do you have frequent headaches?	☐	☐
Do you clench or grind your teeth?	☐	☐
Are you habitual gum chewer or pipe smoker?	☐	☐
Have you had problems with previous dental treatment?	☐	☐
Are you pleased with the appearance of your teeth when you smile?	☐	☐
Are you pleased with the color of your teeth?	☐	☐
Is there any dental treatment you are not happy with?	☐	☐
Are you apprehensive about dental treatment?	☐	☐
Is there any disease, condition or problem not listed above that you think we should know about?	☐	☐

Explain _____

Robert L. Malecki, D.D.S., P.C. 989-892-7663

Welcome. Thank you for selecting our dental team.
Patient's Medical History

Today's Date _____

Patient's Name _____ Date of Birth_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

Have you ever had, or been treated for any of the following diseases or medical problems?

	Yes	No
Abnormal Bleeding	☐	☐
AIDS or HIV	☐	☐
Anemia	☐	☐
Leukemia	☐	☐
Cancer/Chemotherapy/Radiation	☐	☐
Cardiovascular Disease	☐	☐
Congenital Heart Defects	☐	☐
Congestive Heart	☐	☐
Angina	☐	☐
Stents When: _____	☐	☐
Heart Catheterization When: _____	☐	☐
Artificial or Damaged Heart Valve	☐	☐
Heart Bypass When: _____	☐	☐
Irregular Heartbeat	☐	☐
Heart Attack When: _____	☐	☐
Heart Murmur	☐	☐
Stroke	☐	☐
Mitral Valve Prolapse	☐	☐
Cardiac Pacemaker When _____	☐	☐
Blood Transfusion When: _____	☐	☐
Blood Thinner	☐	☐
Phlebitis (Blood Clots)	☐	☐
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐
Rheumatic Fever	☐	☐
Chronic Pain	☐	☐
Heartburn /Acid Reflux	☐	☐
Gastrointestinal Disorders	☐	☐
Stomach Disorders / Ulcer / Colitis	☐	☐
Thyroid Problems	☐	☐
Hemophilia (Bleeding Problems)	☐	☐
Hepatitis, Jaundice, Liver Disease	☐	☐
Kidney Disease / Dialysis	☐	☐

	Yes	No
Depression	☐	☐
Anxiety / Panic Attacks	☐	☐
Alzheimers / Dementia	☐	☐
Osteoporosis	☐	☐
Respiratory Problems:	☐	☐
☐ Asthma		
☐ Emphysema / COPD		
☐ Bronchitis		
☐ Sinus Trouble		
☐ Hay Fever / Allergies to Pollen / Dust		
Diabetes	☐	☐
☐ Type I (Insulin Dependent)		
☐ Type II		
Dry Mouth	☐	☐
Severe or Rapid Weight Loss	☐	☐
Eating Disorder (Current or Past)	☐	☐
If yes, specify: _____		
Bariatric Surgery	☐	☐
When _____		
Dietary Restrictions	☐	☐
Epilepsy / Convulsions	☐	☐
Fainting Spells or Seizures	☐	☐
Glaucoma / Vision Problems	☐	☐
Severe Headaches	☐	☐
Lupus or Autoimmune Disorders	☐	☐
Arthritis / Rheumatoid	☐	☐
Steroid Treatment	☐	☐
Joint Replacement or Implant	☐	☐
When _____		
Any Complications?_____		
Sleep Apnea / Sleep Disorder	☐	☐
Back or Neck Problems	☐	☐
Herpes / Cold Sores	☐	☐

Medical History

Name of Primary Care Physician _____ Phone _____

Physician Address _____

Date of your last physical examination _____

Please list any other specialty physicians involved in your care:

Physician _____ Phone: _____

Physician _____ Phone: _____

Physician _____ Phone: _____

Have you been hospitalized for any surgical operation or serious illness within the last 5 years:

Explain

List any drugs or medicines that you are currently taking...include prescription / non-prescription drugs, aspirin, birth control pills and vitamins.

Drug	Dosage / How Often?	Reason

Have you ever been told you need premedication before dental work? ☐ Yes ☐ No

Are you allergic, or have you reacted adversely, to any of the following?

	Yes	No
Local Anesthetic (Novocain)	☐	☐
Penicillin or Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates, Sedatives or Sleeping Pills	☐	☐
Aspirin, Acetaminophen, or Ibuprofen	☐	☐
Codeine, Demerol, or Other Narcotics	☐	☐
Reaction to Metals (Nickel, Mercury) or Latex	☐	☐
Other _____	☐	☐

Women Only	Yes	No
Are you pregnant? If yes, due date: _____	☐	☐
Are you taking birth control pills?	☐	☐
Could you be pregnant?	☐	☐
Are you nursing?	☐	☐
Hormone Replacement?	☐	☐

When was your last dental visit _____ What was done then _____

How often did you visit the dentist before then _____

Previous dentist (name, address, phone)

Have you had a complete series of dental films (x-rays) taken? when/where

To the best of my knowledge, all of the preceding answers are true and correct.
If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.

Signature of Patient, Parent, or Guardian _____ Date _____