maple street dental group

TODAY'S DATE:	EMAIL ADDRESS:	
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
I PREFER TO BE CALLED:	GENDER: M F	
BIRTHDAY: AGE:	SOCIAL SECURITY:	
HOME ADDRESS:	CITY:	STATE:
ZIP CODE:		
BEST PHONE NUMBER TO REACH YOU:		
OCCUPATION:	EMPLOYER:	
WHOM MAY WE THANK FOR REFERRING YOU:		
PLEASE LIST FAMILY MEMBERS SEEN BY US:		
NAME OF PHYSICIAN:	DATE OF LAST VISIT:	

FOR WOMEN, PLEASE SELECT IF YOU ARE:

NURSING: YES NO	PREGNANT: YES NO
IF PREGNANT, NUMBER OF WEEKS:	
TAKING BIRTH CONTROL PILLS: YES NO	

maple street dental group

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

	ABNORMAL BLEEDING		HEPATITIS		ALCOHOL/DRUG ABUSE
	HERPES/FEVER BLISTERS		ANEMIA		HIGH BLOOD PRESSURE
	ARTHRITIS		HIV+/AIDS		ARTIFICIAL BONES/JOINTS/VALVES
	KIDNEY PROBLEMS		ASTHMA		LIVER DISEASE
	BLOOD TRANSFUSION		LOW BLOOD PRESSURE		CANCER/CHEMOTHERAPY
	HERPES/FEVER BLISTERS		COLITIS		PACEMAKER
	CONGENITAL HEART DEFECT		PSYCHIATRIC PROBLEMS		DIABETES
	RADIATION TREATMENT		DIFFICULTY BREATHING		RHEUMATIC/SCARLET FEVER
	EMPHYSEMA		SEIZURES		EPILEPSY
	SHINGLES		FAINTING SPELLS		SICKLE CELL DISEASE/TRAITS
	FREQUENT HEADACHES		SINUS PROBLEMS		GLAUCOMA
	STROKE		HEMOPHILIA		THYROID PROBLEMS
	HEART ATTACK		TUBERCULOSIS (TB)		HEART MURMUR
	ULCERS		HEART SURGERY		VENEREAL DISEASE
	HOSPITALIZED FOR ANY REASON				

DO YOU REQUIRE ANTIBIOTICS BEFORE DENTAL TREATMENT? YES NO

PLEASE LIST ANY SERIOUS MEDICAL CONDITION(S) THAT YOU HAVE EVER HAD:

maple street
dental group

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

	ASPIRIN		ERYTHROMYCIN		METALS
	CODEINE		JEWELRY		PENICILLIN
	DENTAL ANESTHETICS		LATEX		TETRACYCLINE

OTHER DRUGS/MATERIALS THAT YOU ARE ALLERGIC TO?

YOUR CURRENT PHYSICAL HEALTH IS: GOOD FAIR POOR

ARE YOU TAKING ANY PRESCRIPTION DRUGS? YES NO

PLEASE LIST EACH ONE:

DO YOU SMOKE OR USE TOBACCO? YES NO

HAVE YOU EVER TAKEN FOSAMAX OR ANY BISPHOSPHONATE? YES NO

IF YES TO THE ABOVE, WHEN:

maple street
dental group

WHY HAVE YOU COME TO THE DENTIST TODAY?

	CHECK UP/CLEANING		PAIN
	BROKEN TEETH/DENTAL WORK		COSMETICS

HAVE YOU EVER HAD A SERIOUS / DIFFICULT PROBLEM ASSOCIATED WITH ANY PREVIOUS DENTAL WORK? YES NO

DO YOU NOW OR HAVE YOU EVER EXPERIENCED PAIN/DISCOMFORT IN YOUR JAW JOINT (TMJ / TMD)? YES NO

YOUR CURRENT DENTAL HEALTH IS: GOOD FAIR POOR

DO YOU LIKE YOUR SMILE? YES NO

DO YOUR GUMS EVER BLEED? YES NO

HOW MANY TIMES A WEEK DO YOU FLOSS? 3 OR LESS 4-6 7 OR MORE

HOW MANY TIMES A DAY DO YOU BRUSH? 0 1 2 OR MORE

TYPE OF BRISTLES: SOFT MEDIUM HARD

maple street
dental group

I consent to having the following done: X-rays, Exam, Prophylaxis (cleaning).

I understand that holding my mouth open during treatment may temporarily leave my jaw feeling stiff and sore and may make it difficult for me to open wide for several days. I must notify your office if this or other concerns arise. I understand that if the recommended treatment is not performed, tooth or gum damage may progress causing me to lose one or more of my teeth. I may also experience symptoms that may be damaging to my overall health and which may increase in severity, and the cosmetic appearance of my teeth may deteriorate. I understand that every reasonable effort will be made to ensure the success of my treatment. I understand that each person and situation is unique, and no guarantee or assurance has been given to me by anyone that the proposed treatment will cure or improve my condition(s). INITIAL HERE:

I understand that antibiotics, anesthetics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. I understand that all medications have the potential for accompanying risks, side effects, and drug interactions. Therefore it is critical that I tell my dentist of all medications I am currently taking, which I have done. INITIAL HERE:

I understand that I may have loss of feeling in my teeth, lips, tongue and surrounding tissue (paresthesia) following injections for local anesthesia with any procedure. Rarely, temporary or permanent nerve injury and loss of feeling may result from an injection. INITIAL HERE:

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. INITIAL HERE:

OFFICE USE ONLY

Confirmation of review of medical / dental information above with the patient named herein, and attestation of discussion of the risks, benefits, consequences, and alternatives of proposed treatment. Patient will be given the opportunity to ask questions, and I will ensure the patient understands what has been explained.

maple street
dental group

DR. MATTHEW WEGRZYN

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT.

I, , HAVE BEEN OFFERED 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, as required by law, but acknowledgement could not be obtained because:

	Individual refused to sign
	Communications barriers prohibited obtaining the acknowledgement.
	An emergency situation prevented us from obtaining acknowledgement.
	Other (to be documented in chart notes)