Centre Sky Dentistry, Dr. Craig L. Krizek DDS, MAGD

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Thank you for choosing our office. We will strive to provide you with the best possible care. To help us meet all your dental needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help you. All information will be kept confidential.

PATIENT INFORMATION

Please print

DATE_____

Full Name _____Age_____ Date of Birth_____ Soc Sec #_____

Mailing Address_____ City_____ State_____ Zip_____

Home phone #_____ Cell phone#_____ Work phone #_____ Employer_____

Sex: Male Female E-mail_____ Occupation_____

Please circle appropriately: Minor Single Married Divorced Widowed Separated

Spouse's Name_____

Nearest relative or emergency contact_____ Phone #_____

Answer only if you are a dependent: Mother's Name _____ Father's name_____

Parent's Address (if different from above) _____

Parent's home phone#_____ Parent's work#_____ Parent's cell#_____

PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT:

Name_____ Address_____ Employer_____

Relationship to this patient_____

INSURANCE INFORMATION

Dental Insurance Company_____ Employer_____

Policy#_____ ID#_____ Group#_____

Subscriber's name_____ Social Security #_____ DOB_____

AUTHORIZATION AND RELEASE: I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately and completely answered. I hereby grant permission to the doctor and staff of this office to release information including the diagnosis and the records of any treatment or examination rendered to me to assist in obtaining payment from my insurance carriers. I authorize and request my insurance company to pay directly to the doctor of this practice. I understand that my insurance carrier may pay less than the actual bill for services. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR TO MY DEPENDENTS. I grant permission to the doctors or staff of this office to release medical information to other medical personnel as deemed necessary in treating my current condition.

Patient, parent or guardian signature_____

DENTAL HISTORY - Yes, No, or Don't Know

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐

	Yes	No	DK
Are you currently experiencing dental pain or discomfort?	☐	☐	☐
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:_____ What was done at that time?_____ Date of last dental x-rays:_____

Have you had any problems associated with previous dental treatment _____

How do you feel about your smile?_____

What is the reason for your dental visit today?_____

Health problems that you may have, or medication that you may be taking, could have an important inter-relationship with the dentistry you will receive. Thank you for answering the following questions.

MEDICAL HISTORY

Are you under a physician's care now? Yes No If yes, please specify Dr.'s name & address_____

Are you in good health? Yes No _____

Have you had a serious illness, operation or been hospitalized in the past five years? Yes No _____

Have you had a joint replacement? Yes No If yes, specify hip, knee, elbow, finger Date_____

Have you ever had a serious head or neck injury? Yes No Comments_____

Are you taking any medications? Yes No Please list: _____

Do you use tobacco? Yes No _____

Are you allergic to any of the following: _____

Aspirin____ Codeine____ Acrylic____ Metal____ Latex____ Sulfa Drugs____ Local Anesthetics____

Antibiotics: Please specify_____ Other medication allergies:_____

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Yes No

Women: Y/N Are you... Pregnant/Trying to get pregnant?____ Nursing?____ Taking oral contraceptives?____

Do you have, or have you had, any of the following? Yes, No, or Don't Know

	Yes	No	DK
AIDS/HIV Positive	☐	☐	☐
Alzheimer's Disease	☐	☐	☐
Anaphylaxis	☐	☐	☐
Arthritis/Gout	☐	☐	☐
Artificial Heart Valve	☐	☐	☐
Artificial Joint	☐	☐	☐
Asthma/Bronchitis	☐	☐	☐
Blood Disease, Transfusions, Anemia, Excessive Bleeding	☐	☐	☐
Bone Problems, Back, Neck, Spine	☐	☐	☐
Breathing Problems	☐	☐	☐
Bruise Easily	☐	☐	☐
Cancer	☐	☐	☐
Chemotherapy/Radiation	☐	☐	☐
Cold Sores/Blisters	☐	☐	☐
Congestive Heart Failure	☐	☐	☐
Cortisone Medicine	☐	☐	☐
Diabetes I or II	☐	☐	☐
Drug Addiction	☐	☐	☐
Epilepsy or Seizures	☐	☐	☐
Fainting Spells/Dizzy	☐	☐	☐
Headaches/Migraines	☐	☐	☐
Gastrointestinal Disease/ Reflux/ Heartburn	☐	☐	☐
Glaucoma or other eye problems	☐	☐	☐
Hay Fever	☐	☐	☐
Heart Attack	☐	☐	☐
Heart pacemaker/Heart surgery	☐	☐	☐
Heart trouble/Chest pain/Angina	☐	☐	☐
Hemophilia	☐	☐	☐
High Blood Pressure	☐	☐	☐
Hypoglycemia	☐	☐	☐
Kidney or bladder problems	☐	☐	☐
Leukemia	☐	☐	☐
Liver Disease/Hepatitis/Jaundice	☐	☐	☐
Mitral Valve Prolapse	☐	☐	☐
Neurological Disorders	☐	☐	☐
Osteoporosis	☐	☐	☐
Pain in Jaw Joints	☐	☐	☐
Parathyroid Disease	☐	☐	☐
Psychiatric Care/Anxiety/Depression	☐	☐	☐
Renal Dialysis	☐	☐	☐
Rheumatism	☐	☐	☐
Scarlet Fever	☐	☐	☐
Shingles	☐	☐	☐
Sickle Cell Disease	☐	☐	☐
Sinus/Ears and Nose Trouble	☐	☐	☐
Stroke	☐	☐	☐
Systemic Lupus Erythematosus	☐	☐	☐
Thyroid Disease/Problems	☐	☐	☐
Tuberculosis	☐	☐	☐
Tumors or Growths	☐	☐	☐
Ulcers	☐	☐	☐
Vascular issues/Aorta, Carotid, Deep Vein Thrombosis	☐	☐	☐

Have you ever had any serious illness not listed? Yes____ No____ If yes, please specify:_____

_____

Do you have any physical disability? Yes No _____

Comments:_____

_____

To the best of my knowledge, the questions on the form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of patient, parent or guardian:_____ Date_____