

**Welcome to the Office of Anthony R. Markiewicz D.D.S.**

**Patient Information**

Patient Name: \_\_\_\_\_ Preferred Name \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Last, \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_  
 Male  Female Birth Date: \_\_\_\_\_  Married  Single  Child  Other \_\_\_\_\_

Social Security #: \_\_\_\_\_ Email Address \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Cell Number: \_\_\_\_\_

Address: \_\_\_\_\_  
 \_\_\_\_\_ Street \_\_\_\_\_ Apt # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Referral Information:**  Web Site  Yellow-Pages  Drive-By  School/Parish  Other \_\_\_\_\_  
**Whom may we thank for referring you to our practice?** \_\_\_\_\_

**Health Information**

**PLEASE LIST CURRENT MEDICATIONS (NAME & DOSAGE) YOU ARE TAKING:** \_\_\_\_\_

Date of Last Dental Visit: \_\_\_\_\_ Reason for this visit: \_\_\_\_\_

**Have you ever had any of the following? Please check YES or NO:**

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N            | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N          |
| <input type="checkbox"/> AIDS                         | <input type="checkbox"/> Excessive Bleeding                      | <input type="checkbox"/> Hypoglycemia                 | <input type="checkbox"/> Sickle Cell Anemia                    |
| <input type="checkbox"/> Alzheimer's Disease          | <input type="checkbox"/> Excessive Thirst                        | <input type="checkbox"/> Jaundice                     | <input type="checkbox"/> Sinus Problems                        |
| <input type="checkbox"/> Anemia                       | <input type="checkbox"/> Fainting                                | <input type="checkbox"/> Kidney Disease               | <input type="checkbox"/> Stomach Problems                      |
| <input type="checkbox"/> Arthritis                    | <input type="checkbox"/> Fever Blisters                          | <input type="checkbox"/> Liver Disease                | <input type="checkbox"/> Stroke                                |
| <input type="checkbox"/> Artificial Joints/Hips       | <input type="checkbox"/> Frequent Cough                          | <input type="checkbox"/> Lung Disease                 | <input type="checkbox"/> Swelling of Feet /<br>Ankles or Hands |
| <input type="checkbox"/> Artificial Heart Valve       | <input type="checkbox"/> Glaucoma                                | <input type="checkbox"/> Mental Disorders             | <input type="checkbox"/> Thyroid Disease                       |
| <input type="checkbox"/> Asthma                       | <input type="checkbox"/> Growths                                 | <input type="checkbox"/> Mitral Valve Prolapse        | <input type="checkbox"/> Tuberculosis                          |
| <input type="checkbox"/> Blood Disease                | <input type="checkbox"/> Have you ever taken<br>Phen-Phen/Redux? | <input type="checkbox"/> Nervous Disorders            | <input type="checkbox"/> Tumors                                |
| <input type="checkbox"/> Blood Transfusion            | <input type="checkbox"/> Hay Fever                               | <input type="checkbox"/> Pacemaker                    | <input type="checkbox"/> Ulcers                                |
| <input type="checkbox"/> Bruise Easily                | <input type="checkbox"/> Head Injuries                           | <input type="checkbox"/> Pain in Jaw Joints           | <input type="checkbox"/> Venereal Disease                      |
| <input type="checkbox"/> Cancer                       | <input type="checkbox"/> Heart Disease                           | <input type="checkbox"/> Pregnancy<br>Due date: _____ | <input type="checkbox"/> Yellow Jaundice                       |
| <input type="checkbox"/> Chemotherapy /<br>Radiation  | <input type="checkbox"/> Heart Trouble                           | <input type="checkbox"/> Pre Med                      | <input type="checkbox"/> Allergy: Penicillin                   |
| <input type="checkbox"/> Chest Pain/Angina            | <input type="checkbox"/> Heart Murmur                            | <input type="checkbox"/> Psychiatric Care             | <input type="checkbox"/> Allergy: Latex                        |
| <input type="checkbox"/> Cold Sores                   | <input type="checkbox"/> Heart Surgery                           | <input type="checkbox"/> Radiation Treatment          | <input type="checkbox"/> Allergy: Sulfa Drugs                  |
| <input type="checkbox"/> Cortisone Medicine           | <input type="checkbox"/> Hemophilia                              | <input type="checkbox"/> Recent Weight Loss           | <input type="checkbox"/> Allergy: Ibuprofen                    |
| <input type="checkbox"/> Diabetes                     | <input type="checkbox"/> Hepatitis A / B / C                     | <input type="checkbox"/> Respiratory Problems         | <input type="checkbox"/> Allergy: Tetracycline                 |
| <input type="checkbox"/> Dizziness                    | <input type="checkbox"/> Herpes                                  | <input type="checkbox"/> Rheumatic Fever              | <input type="checkbox"/> Allergy: Aspirin                      |
| <input type="checkbox"/> Drug Addiction               | <input type="checkbox"/> High Blood Pressure                     | <input type="checkbox"/> Rheumatism                   | <input type="checkbox"/> Allergy: Codeine                      |
| <input type="checkbox"/> Emphysema                    | <input type="checkbox"/> Low Blood Pressure                      | <input type="checkbox"/> Scarlet Fever                | <input type="checkbox"/> Allergy: Epinephrine                  |
| <input type="checkbox"/> Epilepsy or Seizures         | <input type="checkbox"/> HIV Positive                            | <input type="checkbox"/> Shortness of Breath          | <input type="checkbox"/> Allergies: _____                      |

What are your dental goals? \_\_\_\_\_

Do you have a specific dental problem? Describe \_\_\_\_\_ Yes No

Do you have dental examinations on a routine basis? Last visit \_\_\_\_\_ Yes No

Do you have active decay or gum disease? \_\_\_\_\_ Yes No

Do you brush and Floss on a routine basis? Discuss \_\_\_\_\_ Yes No

Do your gums ever bleed? Discuss \_\_\_\_\_ Yes No

Does food catch between your teeth? Any loose teeth? \_\_\_\_\_ Yes No

Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? \_\_\_\_\_ Yes No

Have your past experiences in a dental office always been positive? \_\_\_\_\_ Yes No

Do you smoke or chew? Any sores or growths in you mouth? Discuss \_\_\_\_\_ Yes No

Name of previous dentist: \_\_\_\_\_ City: \_\_\_\_\_

Date of last full mouth x-rays (16 small films or panoramic): \_\_\_\_\_

**Note to Women:** Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician or gynecologist for assistance regarding additional or alternative methods of birth control.

- Have you ever had any complications following dental treatment?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you been admitted to a hospital or needed emergency care during the past two years?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Are you now under the care of a physician?  Yes  No If yes, please explain: \_\_\_\_\_
- Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_
- Do you have any health problems that need further clarification?  Yes  No If yes, please explain: \_\_\_\_\_

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctors at the next appointment without fail.

X \_\_\_\_\_ Date: \_\_\_\_\_  
 Signature of patient, parent or guardian

Health History Reviewed:

X \_\_\_\_\_ Date: \_\_\_\_\_  
 Dentist Signature

### Responsible Party Information

Name: \_\_\_\_\_  Male  Female  Married  Single  Other \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Cell Number: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street Apartment # City State Zip Code

In case of emergency, whom shall we call: Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone Numbers: \_\_\_\_\_

### Insurance Information

#### Primary Insured Persons Information:

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ ID or SS#: \_\_\_\_\_  
Last First MI  
Address: \_\_\_\_\_  
Street City State Zip Code  
Employer Name & Address: \_\_\_\_\_ Group#: \_\_\_\_\_  
Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_  
Insurance Plan Name and Phone Number: \_\_\_\_\_

#### Secondary Insured Persons Information:

Name: \_\_\_\_\_ Birth Date \_\_\_\_\_ ID# \_\_\_\_\_  
Last First MI  
Address: \_\_\_\_\_  
Street City State Zip Code  
Employer Name & Address: \_\_\_\_\_ Group#: \_\_\_\_\_  
Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_  
Insurance Plan Name & Phone Number: \_\_\_\_\_

### Patient Consent and Financial / Insurance Authorization

As a condition of treatment by this office, I understand financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for in cash at the time the services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

RELEASE AND STATEMENT TO PERMIT PAYMENT OF PRIVATE INSURANCE BENEFITS TO PROVIDER: I the undersigned patient and/or responsible party hereby jointly authorize Anthony R. Markiewicz D.D.S., its agents/employees to release any information including diagnosis and the records of any treatments or examination rendered to me or my child(ren) during the period of such dental care, to third party payors and/or other health care practitioners.

If my coverage is under a group master agreement held by my employer, and association, trust fund, union or similar entity, this authorization also permits disclosure to time for purposes of utilization review or financial audit.

I authorize and request my insurance company to pay directly to Anthony R. Markiewicz D.D.S., insurance benefits otherwise payable to me.

I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed to dates, I understand that a 1 1/2% finance charge (18%APR) may be added to my account, in addition to any collection charges. I hereby authorize Anthony R. Markiewicz D.D.S., to release all information necessary to secure the payment of benefits. I authorize the use of this signature of all my insurance submissions, whether manual or electronic.

I grant my permission to you, or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

**X** \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Signature of Responsible Party / Parent or Guardian