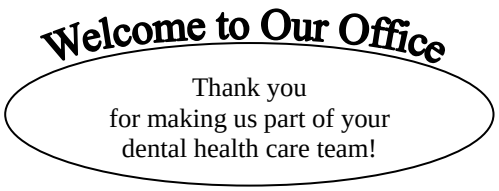

PATIENT REGISTRATION

(*Please Print*)

Circle: Mr. Mrs. Ms. Dr. Rev Male Female Minor Single Married Divorced Widowed Separated

Patients Name _____
Last Name *First Name* *Middle*

Address _____
Street *City* *State* *ZIP*

Date of Birth _____ Social Security No. _____
Hobbies _____ Occupation _____
HomeTel _____ WorkTel _____Mobile/Pager _____
Employer _____
Person to Contact in Case of Emergency_____ Phone_____

Whom may we thank for referring you? _____

Who is your family dentist? _____

Person Responsible for Account _____
Social Security No. _____ Date of Birth _____
Relationship to Patient: Self____ Spouse____ Parent ____ Other _____
Home Phone _____ Work Phone _____

Dental Insurance Information
Name of Insured Employee_____ Soc. Security No._____
Employer_____ Work #_____
Insurance Co._____ Ins. Co. #_____
Ins Co. Address_____
Group #_____ Insured Date of Birth_____

Payment Method –Informed Consent
I understand that this office will accept an insurance benefit payment with the patient's co-payment being due at the time of service. I understand that insurance benefits given at the time of service are only estimates and that I am responsible for the entire balance after the insurance benefit. In cases in which reimbursement is sent directly to the patient from the insurance company, full payment is due at the time of service. We gladly welcome any questions regarding fees and discussing your financial options prior to treatment.

Note: All balances are due at the time of service. Please check method of payment below.
[ ] Cash [ ] Check [ ] Visa [ ] MC [ ] Amex

I authorize Dr. Wolanek to use my x-rays and photos for presentations and publications. I authorize my insurance carrier to issue the dental benefits directly to this office and also the release of any information necessary to process the dental insurance.

I give Dr. Wolanek's Dental Practice, its employees and/or agents "express prior consent" to contact me at any/all phone numbers, including cell phone numbers (by phone call or text message), for the purpose of treatment, insurance, or payment.

Signature: _____ Date:_____

Health Questionnaire

Note: This information is confidential and essential to provide the best possible care for you.

Physician's Name (Medical Doctor) _____

Please check YES or NO to answer the following questions and provide explanations where needed:

1. Have you been treated by a doctor or been in the hospital in the last 2 years? Yes_____ No _____ If yes, why?

2. Are you taking any medication at this time or recently? Yes_____ No _____ If yes, please list the medications.

3. Have you ever had an allergic or unusual reaction to any of the following medications? *Please circle Yes or No.*

Dental Local Anesthetics	Yes	No	Penicillin	Yes	No
Aspirin	Yes	No	Erythromycin	Yes	No
Codeine or other Narcotics	Yes	No	Tylenol	Yes	No
Barbiturates or Tranquilizers	Yes	No	Others_____	Yes	No

4. Have you had, or do you presently have, any of the following conditions? *Please Circle Yes or No*

Angina or Chest Pain	Yes	No	Diabetes	Yes	No
Heart Murmur	Yes	No	Chemotherapy or Radiation Treatment	Yes	No
Rheumatic Fever	Yes	No	AIDS or HIV Positive	Yes	No
Congenital Heart Lesion	Yes	No	Hepatitis, Jaundice, or Liver Disease	Yes	No
Artificial Heart Valve	Yes	No	Hemophilia or Excessive Bleeding	Yes	No
Heart Pacemaker	Yes	No	Sexually Transmitted Diseases	Yes	No
Artificial Joint	Yes	No	Asthma	Yes	No
Stroke	Yes	No	Mental Disorders	Yes	No
Kidney Disease	Yes	No	Stomach or Intestinal Ulcers	Yes	No
Cancer or Tumors	Yes	No	Hay Fever or Sinus Trouble	Yes	No
Lung Disease	Yes	No	Thyroid Disease	Yes	No
Tuberculosis	Yes	No	Drug or Alcohol Problem	Yes	No
High Blood Pressure	Yes	No	Arthritis	Yes	No
Low Blood Pressure	Yes	No	Told Not to Give Blood	Yes	No
Heart Attack	Yes	No	Epilepsy	Yes	No

5. *Women only:*

Are you pregnant?	Yes	No	If so, how many months? _____
Are you taking birth control pills?	Yes	No	
Are you breast feeding your child?	Yes	No	

6. Has your physician recommended premedication with antibiotics prior to dental treatment? If so, for what reason?

7. Is there any other aspect of your medical history that has *not* been covered in the above questions?

To the best of my knowledge, all the preceding answers are true and correct. If changes in my health or medicines occur, I will inform the staff of Dr. Gary A. Wolanek prior to treatment.

Signed: _____ Dated:

Patient or Guardia (If patient is a minor)