

Thank you for selecting our dental healthcare team.
We strive to provide you the best possible dental care.
Please help us meet all your dental healthcare needs by filling out this for completely in ink.
If you have any questions or need assistance, please ask us. We are happy to help.

Dr. Philip J. Martowski, D.D.S.
886 Dahlia Lane
Vero Beach, FL 32963
(772) 231-6949

Welcome!

Patient Information (Confidential)

Name _____ Birthdate _____ Home Phone _____

Local Address _____ City _____ State _____ Zip _____

E-mail Address _____ Cell # _____

Northern Address _____ City _____ State _____ Zip _____

Circle Appropriate Minor Single Married Divorced Widowed Separated

Patient's or Parent's Employer _____ Work # _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____

Work # _____

If patient is a student, Name of school/college _____ City _____ State _____

Preferred Method of Contact (circle appropriate): Phone Call Text Message* Email

* Msg & data rates may apply

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of person responsible for this account _____ Relationship to Patient _____

Address _____ Home Phone _____

Driver's License # _____ Birthdate _____

Cell Phone _____ Work Phone _____

Is this person currently a patient in our office: Yes No

Dental Insurance Information

Name of insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Approx. Date Employed _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Phone _____

Insurance Address _____ City _____ State _____ Zip _____

Group Number _____

Medical History Continued

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment. _____

We acknowledge the benefit of taking dietary supplements or herbal medicines.

Circle the supplements you regularly take below:

Diet or Energy Supplements Echinacea Garlic Ginger Ginko Ginseng
Kava St. John's Wort Valerian Vitamin E>400I.U. Fish Oil>3grams/day

List all medication, supplements, and vitamins taken within the last 2 years.

<u>Drug</u>	<u>Purpose</u>	<u>Drug</u>	<u>Purpose</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Ask for additional sheet if you are taking more than 12 medications.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature: _____ Date: _____

CONSENT

1. The undersigned hereby authorizes doctor to take x-ray films, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended **treatment mutually agreed upon** by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____
3. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
4. 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 of services are rendered unless other **mutually agreed upon** arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that 1.5% monthly finance charge (18% APR) may be added to my account, in addition to any collection charges.
5. I understand that a NOTICE OF PRIVACY PRACTICES is available at any time from the front office personnel. This notice describes how health information about you may be used and disclosed and how you may gain access to this information.
6. **I understand that it is my responsibility to advise your office of any changes in the information contained in this form.**

Patient Signature _____ Date _____

Witness _____ Date _____

Parent or Responsible Party _____ Relationship to Patient _____

FOR OFFICE USE: Reviewed by Doctor _____ Date _____

Dental History

Referred by _____ How would you rate the condition of your mouth Excellent Good Fair Poor

Previous Dentist _____ How long have you been a patient? _____ Months/Years

Date of the most recent dental exam _____ Date of the most recent x-ray films _____

Date of most recent treatment (other than cleaning) _____

I routinely see my dentist every:

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

YES NO

PERSONAL HISTORY

1. If you are fearful or dental treatments, please rate your fear on a scale of 1 to 10(very) _____
2. Have you ever had an unfavorable dental experience? _____ YES NO
3. Have you ever had complications from a past dental treatment? _____ YES NO
4. Have you ever had trouble getting numb or reactions to local anesthetic? _____ YES NO
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ YES NO
6. Have you had any teeth removed? _____ YES NO

SMILE CHARACTERISTICS

7. Is there anything about the appearance of your teeth that you would like to change? _____ YES NO
8. Have you ever whitened (bleached) your teeth? _____ YES NO
9. Are you self conscious about your teeth? _____ YES NO
10. Have you been disappointed with the appearance of previous dental work? _____ YES NO

BITE AND JAW JOINT

11. Do you/would you have any problems chewing gum? _____ YES NO
12. Do you/would you have any problems chewing bagels or other hard foods? _____ YES NO
13. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ YES NO
14. Are your teeth crowding or developing spaces? _____ YES NO
15. Do you have more than one bite or do you clench (squeeze) to make your teeth fit together? _____ YES NO
16. Do you have any problems with sleep or wake up with an awareness of your teeth? _____ YES NO
17. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ YES NO
18. Do you have tension headaches or sore teeth? _____ YES NO
19. Do you wear or have you ever worn a bite appliance? _____ YES NO

TOOTH STRUCTURE

20. Have you had any cavities within the past years? _____ YES NO
21. Do you have a dry mouth? _____ YES NO
22. Are any teeth sensitive to hot, cold, biting, or sweets? _____ YES NO
23. Have you ever had a toothache, cracked filling, broken, chipped, or cracked tooth? _____ YES NO
24. Do you avoid brushing any part of your mouth? _____ YES NO
25. Do you feel or notice any holes (pitting) in your teeth? _____ YES NO

GUM OR BONE

26. Have you ever been diagnosed or treated for periodontal (gum) disease? _____ YES NO
27. Have you ever experienced gum recession? _____ YES NO
28. Is there anyone with a history of periodontal disease in your family? _____ YES NO
29. Do your gums bleed when brushing, flossing, or eating? _____ YES NO
30. Are your teeth becoming loose? _____ YES NO
31. Have you ever noticed an unpleasant taste or odor in your mouth? _____ YES NO
32. Have you experienced a burning sensation in your mouth? _____ YES NO

Patient Signature _____ Date _____

Doctor's Signature _____ Date _____