

LEE M. FRIEDEL, D.D.S.

ELISE BOLSKI, D.D.S..

It is a pleasure to welcome you to our office. We will do our best to make your appointment as convenient as possible. If at any time you have any questions regarding your treatment, your appointment or fees, please feel free to ask. Kindly fill out and sign the following form concerning your medical and dental history to aid us in preparing our office files.

Date: _____

Name: _____ Patient's Birthdate: _____ Nickname: _____

Address: _____ City: _____ Zip: _____

Telephone: (____) _____ Business #: (____) _____ SS#: _____

Marital Status: _____ Spouse's Name (Parent or Guardian if Minor): _____

Employer: _____ Bus. Address: _____

Other family members living at the same address: _____ Responsible Party: _____

Person Providing Insurance: _____ Insured Birthdate: _____

Dental Insurance Company Name: _____ Policy/Group#: _____

Insured Employer's Name: _____ Insured S.S.#: _____

Insurance Co. Address: _____ Ins. Co. Phone #: (____) _____

What prompted you to seek dental care at this time? _____

Reason for leaving former dentist: _____ Referred by: _____

How long since you have been to a dentist? _____ Since had dental x-rays? _____

Previous Dentist name to call for x-rays _____ Previous Dentist Phone # (____) _____

YES NO

Do you grind or clench your teeth? YES NO

MEDICAL HISTORY

Are you in good health? YES NO

NO

Explain: _____

Are you taking any medications? (e.g. Coumadin, Bloodthinners, Cortisone, Insulin, Digitalis, Dilantin) YES NO

List: _____

Do you have or have you ever had any of the following diseases or problems? (Please check all that apply)

- ___ Surgery ___ Anemia or Blood Disorders ___ Drug Allergies or Adverse Drug Reactions
___ Heart Disease ___ Gastro Intestinal ___ Depression
___ Heart Murmur/Mitral Valve Prolapse ___ Respiratory Disease (Asthma) ___ Venereal Disease/Herpes
___ Cancer ___ Diabetes ___ AIDS/ARC/HIV+
___ High Blood Pressure ___ Hepatitis ___ Convulsions or Epilepsy
___ Low Blood Pressure ___ Jaundice or Liver Disease ___ Latex Allergy
___ Stroke ___ Thyroid CHECK ___ NONE OF THE ABOVE

Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? YES NO

Do you have any prosthetic replacements? (e.g. Hip, Knee, Heart Valve) YES NO

Have you ever been required to take antibiotics prior to dental procedures? YES NO

Comments: _____

Upon signing, I understand that I will be charged 1.5% per month (18% annually) on all unpaid balances 90 days past due.

Signature: _____ Update: _____