JOHN A. HUDEC, D.D.S.
& ASSOCIATES, INC.

Date ________________

"Making smiles that last."

Welcome!
In order for us to thoroughly diagnose and plan your dental treatment, we must have accurate background and health information. Please provide the information requested below so that we can give you our best consideration during your initial visit to our office.

Name ____ Nickname ____ Home Phone ____

Email ____ Cell Phone ____

Birthdate ____ M/F ____ Age ____ S.S. # ____

Home Address ____ City ____ Zip Code ____

Name of Spouse/ or Parent If Minor ____ Spouse's or Parent's Employer ____ Spouse's or Parent's S.S. # ____

Employer ____ Telephone: Business ____

Business Address ____ Driver's License No. ____

How did you first hear about us? ☐ drive by ☐ insurance referral ☐ yellow pages ☐ radio
☐ friend/family ________________ (Name) ☐ doctor's office ☐ website ☐ direct mail

If Patient is a minor, who is financially responsible for this bill? (Last Name, First Name) ____ S.S. # ____ Employer: ____ D.O.B.: ____

Do you have dental insurance? Yes No If so, what company? ____ Group # ____

Preferred Method of Payment ☐ Cash/Check ☐ MC/Visa ☐ American Express ☐ Discover

Whom may we contact in case of emergency? ____ Relationship ____ Telephone # ____

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

How long since your last thorough dental examination? ____ Name of Dentist ____

Are you satisfied with your past dentistry? ____ If not, why? ____

Name of physician ____ Telephone # ____

Are you under care of a physician now? ____ For what reason? ____

Are you allergic to: Penicillin ☐ Codeine ☐ Local anesthetics ☐ Latex ☐ Other ☐ If other, what? ____ None ☐

Do you have any problems with any medications? ____

What medicines are you now taking? ____ For what purpose? ____

Women: Are you pregnant? ____ Do you anticipate becoming pregnant? ____ Are you nursing? ____

Have you ever been treated for:

	Yes	No		Yes	No		Yes	No		Yes	No
Mitral valve prolapse	☐	☐	Artificial joint	☐	☐	Chemotherapy / Radiation	☐	☐	Alcohol or drug addiction	☐	☐
Heart disease or attack	☐	☐	Anemia	☐	☐	(Cancer, Leukemia)	☐	☐	Emphysema	☐	☐
Angina Pectoris	☐	☐	Stroke	☐	☐	Arthritis	☐	☐	Hemophilia	☐	☐
Congenital heart lesions	☐	☐	Tuberculosis	☐	☐	Rheumatism	☐	☐	Venereal disease	☐	☐
Heart murmur	☐	☐	Asthma	☐	☐	Kidney trouble	☐	☐	Cold sores	☐	☐
Artificial heart valve	☐	☐	Hay fever	☐	☐	Hepatitis	☐	☐	Epilepsy or seizures	☐	☐
Heart pacemaker	☐	☐	Sinus trouble	☐	☐	HIV Virus / AIDS	☐	☐	Fainting or dizzy spells	☐	☐
High blood pressure	☐	☐	Allergies or hives	☐	☐	Jaundice	☐	☐	Sickle cell disease / trait	☐	☐
Rheumatic fever	☐	☐	Diabetes	☐	☐	Blood transfusion	☐	☐	Ulcers	☐	☐
Migraine headaches	☐	☐	Frequent ear pain	☐	☐	Do you smoke?	☐	☐	Liver disease	☐	☐
Scarlet fever	☐	☐	Thyroid disease	☐	☐	Do you chew tobacco?	☐	☐	Clicking or jaw-joint pain	☐	☐

When you walk up stairs or take a walk, do you have to stop because of pain in the chest, shortness of breath, or tiredness? ☐ Yes ☐ No

When and how often do you brush your teeth? ____

Do your gums bleed easily, feel tender or irritated? ☐ Yes ☐ No

Are your teeth ever sensitive? ☐ Yes ☐ No If yes, what are they sensitive to? ____

Are you aware of grinding or clenching your teeth? ____

Is there anything you would like to change about the way your smile looks? ____

To the best of my knowledge, all of the preceding answers are true and correct. If there ever is a change in my health, or if my medicines change, I will inform the dentist before my next appointment without fail.

Signature of patient, parent, or guardian ____ Date ____