Welcome

Gregory Potempa DDS
Warrensville, IL 60555

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form completely as you can. If you have questions we'll be glad to help you.

We look forward to working with you in maintaining your dental health.

Patient Information

Name: _____ Soc. Sec. #: _____

Address: _____

City: _____ State: _____ Zip:_____ Home Phone: _____

Cell Phone: _____ Email:_____

Sex: M F Age:_____ Birthdate: _____ Single Married Widowed Separated Divorced

Patient Employed By: _____ Occupation: _____

Business Address:_____Business Phone: _____

Business Email:_____

Whom may we thank for referring you?: _____

Notify in case of emergency:_____ Home Phone: _____

Cell Phone: _____Business Phone: _____

Email:_____

Primary Insurance

Person Responsible for Account _____

Relation to Patient: _____ Birthdate: _____ Social Sec. #_____

Address (if different from patient): _____

City: _____ State: _____ Zip:_____ Home Phone: _____

Cell Phone: _____ Email:_____

Person Responsible Employed by: _____Occupation:_____

Business Address:_____Business Phone:_____

Business Email:_____

Insurance Company: _____

Insurance Email: _____

Contract #:_____ Group #: _____ Subscriber #: _____

Name of other dependents under this plan: _____

Additional Insurance

Is patient covered by additional insurance? Yes No

Subscriber Name: _____Relation to Patient: _____ Birthdate: _____

Address (if different from patient): _____

City: _____ State: _____ Zip:_____ Home Phone: _____

Cell Phone: _____ Email:_____

Subscriber Employed by:_____Business Phone: _____

Business Address:_____

Insurance Company: _____ Phone: _____

Insurance Address: _____

Contract #:_____ Group #: _____ Subscriber #: _____

Name of other dependents under this plan: _____

Please complete both sides.

Dental History

What would you like us to do today?: _____Are you in dental discomfort today?: _____
Former Dentist: _____
Address: _____ Phone: _____
Dentist's Email: _____
Date of last dental care:_____ Date of last x-rays: _____
Check (√) yes or no if you have add problems with any of the following:

Y N Bad Breath	Y N Sensitivity to cold
Y N Food collection between teeth	Y N Sensitivity to biting
Y N Periodontal treatment	Y N Clicking or popping jaw
Y N Sensitivity to sweets	Y N Loose teeth or broken fillings
Y N Bleeding gums	Y N Sensitivity to hot
Y N Grinding or clenching teeth	Y N Sores or growths in mouth

How often to you brush?:_____ Floss?: _____
How do you feel about the appearance of your teeth?:_____
Y N Have you ever experienced as adverse reaction during or in conjunction with a medical or dental procedure?
Other information about your dental health or previous treatment: _____

Medical History

Physician's name: _____Phone:_____Date of last visit: _____
Y N Have you had any serious illness or operations?
If yes, describe: _____
Y N Are you currently under physician care
If yes, describe: _____
Y N Have you ever had a blood transfusion?
If yes, give approximate dates: _____
Y N Have you ever taken Fen-Phen/Redux?
Women: Are you pregnant? Y N Nursing Y N Taking birth control pills Y N

Check (√) yes or no whether you have had any of the following:

Y N AIDS/HIV positive	Y N Fainting	Y N Rapid weight gain or loss
Y N Anaphylaxis	Y N Food allergies	Y N Radiation treatment
Y N Anemia	Y N Glaucoma	Y N Respiratory disease
Y N Arthritis/ Rheumatism	Y N Headaches	Y N Rheumatic / Scarlet fever
Y N Artificial heart valves	Y N Heart murmur	Y N Shingles
Y N Artificial joints	Y N Heart problems	Y N Shortness of breath
Y N Asthma	Describe: _____	Y N Skin rash
Y N Atopic (allergy prone)	Y N Hemophilia/ Abnormal bleeding	Y N Spina Bifida
Y N Back Problems	Y N Herpes	Y N Stroke
Y N Blood disease	Y N Hepatitis	Y N Surgical implant
Y N Cancer	Y N High blood pressure	Y N Swelling of feet or ankles
Y N Chemical dependency	Y N Jaw pain	Y N Thyroid disease or malfunction
Y N Chemotherapy	Y N Kidney disease or malfunction	Y N Tobacco habit
Y N Circulatory problems	Y N Liver disease	Y N Tonsillitis
Y N Cortisone treatments	Y N Material allergies (latex, wool, metal, chemicals)	Y N Tuberculosis
Y N Cough, persistent	Y N Mitral valve prolapse	Y N Ulcer/Colitis
Y N Cough up blood	Y N Nervous problems	Y N Venereal disease
Y N Diabetes	Y N Pacemaker/ Heart surgery	
Y N Epilepsy	Y N Psychiatric care	

Is patient currently taking any medications? If yes, list all: _____
_____
Does patient have any drug allergies? If yes, please list all:_____
_____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist. I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature: _____ Date:_____

Payment is due in full at time of treatment, unless prior arrangements have been approved.