Donald J. "Chip" Paluska, DMD

Patient Information Form

Patient Name	Guardian Name (if patient is a minor)	Date
Preferred Name	**Address**	**City, State ,Zip**
Home Phone	**Cell Phone**	**Work Phone**
Email Address	**Date of Last Dental Visit**	**Date of Last Dental X-Rays**
Former Dentist	**Former Dentist's Phone Number**	**Former Dentist's Address**
Birthdate	**Reason for Today's Visit**	**Who May We Thank for Referring You?**

Financial Information

Insurance Company	Employer (if insured through employer)	Policy Holder
Policy Holder's Date of Birth	**Policy Holder's Identification Number**	**Group Number**

Dental Health History

Yes	No		Yes	No		Additional Info
☐	☐	Bad Breath	☐	☐	Bleeding Gums	
☐	☐	Clicking or Popping Jaw	☐	☐	Food Collection Between Teeth	
☐	☐	Grinding Teeth	☐	☐	Loose Teeth or Broken Fillings	
☐	☐	Periodontal Treatment	☐	☐	Sensitivity to Cold	
☐	☐	Sensitivity to Hot	☐	☐	Sensitivity to Sweets	
☐	☐	Sensitivity when Biting	☐	☐	Sores or Growths in Mouth	

How Often Do You Floss?	How Often Do You Brush?

Medical History

Physician's Name	Emergency Contact Name	Emergency Contact Number

Describe any Serious Illnesses and Operations

Have You Had a Blood Transfusion? If Yes, Give Approximate Dates

Yes	No		Yes	No	
☐	☐	Anemia	☐	☐	Arthritis/Rheumatism
☐	☐	Artificial Heart Valve	☐	☐	Artificial Joints
☐	☐	Asthma	☐	☐	Back Problems
☐	☐	Blood Disease	☐	☐	Cancer
☐	☐	Chemical Dependency	☐	☐	Chemotherapy
☐	☐	Circulatory Problems	☐	☐	COPD
☐	☐	Cortisone Treatments	☐	☐	Cough, Persistent
☐	☐	Cough up blood	☐	☐	Diabetes
☐	☐	Epilepsy	☐	☐	Excessive Bleeding
☐	☐	Fainting	☐	☐	Glaucoma
☐	☐	Headaches	☐	☐	Head Injuries
☐	☐	Heart Murmur	☐	☐	Heart Problems
☐	☐	Hemophilia	☐	☐	Hepatitis
☐	☐	High Blood Pressure	☐	☐	HIV
☐	☐	Jaw Pain	☐	☐	Kidney Disease
☐	☐	Liver Disease	☐	☐	Mental Disorders
☐	☐	Mitral Valve Prolapse	☐	☐	Nervous Problems
☐	☐	Pacemaker	☐	☐	Psychiatric Care
☐	☐	Radiation Treatment	☐	☐	Respiratory Disease
☐	☐	Rheumatic Fever	☐	☐	Scarlet Fever
☐	☐	Scleroderma	☐	☐	Shortness of Breath
☐	☐	Sinus Problems	☐	☐	Skin Rash
☐	☐	Stomach Problems	☐	☐	Stroke
☐	☐	Swollen Feet/Ankles	☐	☐	Thyroid Problems
☐	☐	Tobacco Habit	☐	☐	Tonsillitis
☐	☐	Tuberculosis	☐	☐	Tumors
☐	☐	Ulcer	☐	☐	Venereal Disease
☐	☐	Women: Are You Pregnant?	☐	☐	Women: Are you Nursing?
☐	☐	Women: On Birth Control Pills?			

Additional Info

Medications

List All the Medications You Are Currently Taking

Pharmacy Name

Phone Number

Allergies

Yes	No		Yes	No	
☐	☐	Amoxicillin	☐	☐	Anesthetic
☐	☐	Aspirin	☐	☐	Codeine
☐	☐	Erythromycin	☐	☐	Latex
☐	☐	Penicillin	☐	☐	Sulfa
☐	☐	Vicoden			

Additional Info

Please List All Other Allergies

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

If signing for a minor, I do hereby request and authorize the dental staff to perform necessary dental services for the patient, including, but not limited to X-rays, and the administration of anesthetics which are deemed advisable by Dr. Paluska, whether or not I am present at the actual appointment when the treatment is rendered. It has been advised to me, however, that I accompany the minor to any and all dental appointments and I have agreed to do so.

I acknowledge that payment is due at the time of treatment. I agree that I am responsible for all fees and services rendered and accept financial responsibility for all charges, whether they are covered by insurance or not.

(Signature of Patient, Guardian of Patient or Legal Representative) *(Date)*