Dan W. Rajek, D.D.S., S.C.
301 East Second St.
Merrill, WI 54452
(715) 536-2282
www.danrajek.com

PATIENT INFORMATION

Date of Birth: _____ Gender: _____

Patient Name: _____ Social Security #: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Address: _____ _____
Street City State Zip Code

HEALTH INFORMATION

NEW PATIENTS: Date of last dental visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check all that apply:

- ☐ AIDS
- ☐ Allergies: _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial joints: _____
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy: Due Date _____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Other: _____

_____

_____

_____

_____

- Have you ever had any complications following dental treatment? ☐ YES ☐ NO
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years: ☐ YES ☐ NO
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ YES ☐ NO
  If yes, please explain: _____

  Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ YES ☐ NO
  If yes, please explain: _____
- Are you currently taking or have taken Fen-Phen ? ☐ YES ☐ NO
- Are you currently taking or have taken Redux? ☐ YES ☐ NO
- Are you currently taking or have taken Bisphosphonates? (including: Actinol, Phosomax, Boniva, Didronel, Skelid, Aredia, and Zometa) ☐ YES ☐ NO

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor or hygienist at the next appointment.

_____ _____
Signature of patient, parent or guardian Date