

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:

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

- 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