Dr. Daniel Skotzko dds
Family, Cosmetic, Implant & General Dentistry

WELCOME TO OUR PRACTICE

PATIENT INFORMATION Date_____

Last Name_____Title_____First Name_____

Middle Name_____ Nick Name_____ Sex: M / F

Address _____ City_____ State_____ Zip_____

Home Phone _____-_____-_____Work Phone_____-_____-_____Cell Phone _____-_____-_____.

SS#_____DOB _____/_____/_____. Drivers License # _____

Marital Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Email_____

❑ Spouse or ❑ Parent Information (if patient is a minor) ❑ Emergency contact

Last Name_____Title_____First Name_____

Middle Name_____ Nick Name_____ Sex: M / F Relation to Patient_____

Address _____ City_____ State_____ Zip_____

Home Phone _____-_____-_____Work Phone_____-_____-_____Cell Phone _____-_____-_____.

SS#_____DOB _____/_____/_____.

Whom may we thank for referring you to our practice?_____

Present Dental Concern

Do you have any discomfort now? ❑ None ❑ Some, Describe_____

Please describe your chief dental concern that brings you to our office today: _____

_____

Dental Questionnaire

Name of previous dentist _____ Phone _____

Date of last visit_____ Date of last x-rays_____

In the past,how often have you gone to the denitst? ❑ Regularly ❑ Occasionally ❑ Emergencies only

Have you followed your dentist's recommendations? ❑ Regularly ❑ Occasionally ❑ Rarely

Have you had problems or pain with past dentistry? ❑ No ❑ Yes/ moderate ❑ Yes/ Serious

Dentistry for you and your family is a: ❑ High priority ❑ Moderate priority ❑Low Priority

Do you ever have the following?

Mouth:

❑ Bleeding/ sore gums ❑ Unpleasant taste/ bad breath ❑ Burning tongue/ lips

❑ Frequent blisters (lips/mouth) ❑ Swelling/ lumps in mouth ❑Ortho Treatment (braces)

❑ Biting cheeks/ lips ❑ Acid Reflux ❑ clicking/ popping jaw

Teeth:

❑Loose teeth ❑ Sensitive to Hot ❑ Sensitive to Cold

❑ Sensitive to sweets ❑ Sensitive to biting ❑ Food impaction

❑ Shift/ change in bite ❑ Clenching/ grinding if so, when? _____

Medical Questionnaire:

Are you under a doctor's care at this time? ❑ No ❑ Yes, If yes, Why?_____

Doctors Name: _____ Doctor's Phone _____

Are you currently taking any medications? ❑NO ❑Yes if yes please list:

Name of medication	Dosage	How often	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If you need additional space to list medications we will be happy to provide another sheet.

Allergy to: ❑ Penicillin ❑ Erythromycin ❑ Codeine ❑ Sulpha ❑ Dental Anesthetics

Other: _____

Do you smoke or use tobacco? ❑ No ❑ Yes If yes, how much per day? _____

Please check all of the following which you have had or have at the present time:

❑ Abnormal Bleeding	❑ Drug Abuse	❑ Low Blood Pressure
❑ Alcohol Abuse	❑ Emphysema	❑ Mitral Valve Prolapse
❑ Allergies	❑ Epilepsy	❑ Pace Maker
❑ Anemia	❑ Fainting Spells	❑ Psychiatric Problems
❑ Angina Pectoris	❑ Fever Blisters	❑ Radiation Therapy
❑ Anxiety	❑ Frequent Headaches	❑ Rheumatic Fever
❑ Arthritis	❑ Glaucoma	❑ Seizures
❑ Artificial Bones/Joints	❑ HIV/AIDS	❑ Shingles
❑ Artificial Heart Valve	❑ Heart Attack	❑ Sickle Cell Disease
❑ Asthma	❑ Heart Murmur	❑ Sinus Problems
❑ Blood Transfusion	❑ Heart Surgery	❑ Stroke
❑ Cancer-Chemotherapy	❑ Hemophilia	❑ Thyroid Problems
❑ Colitis	❑ Hepatitis A/B/C	❑ Tuberculosis
❑ Congenital Heart Defect	❑ High Blood Pressure	❑ Ulcers
❑ Diabetes	❑ Kidney Problems	
❑ Difficulty Breathing	❑ Liver Disease	

If female, please answer the following: Are you taking Birth Control Pills? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No If Yes, How many weeks? _____

Are you nursing? ❑ Yes ❑ No

I certify that I have read and understand the above information to the best of my knowledge and that the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. Initial _____ .

Consent to Treatment: I understand that with any dental treatment (or lack there of) there may be complications and risks resulting from medications, analgesics(pain killers), the use of dental instruments, anesthetics, and injections including (but not limited to) sensitivity, swelling, bleeding, pain, infection, numbness and tingling in the lip, tongue, chin, gums, cheeks and teeth (which is usually transient but, on occasion, may be permanent), reaction to injections, changes in occlusion(biting), jaw muscle cramps and spasms, temporomandibular (jaw) difficulty, referred pain to ear, neck, and head, nausea and vomiting, allergic reactions, delayed healing and treatment failure. Options (if any) will be discussed at my request, prior to starting treatment. I am aware of these possible complications and wish to start treatment with Doctor Skotzko's office at this time.

_____ _____

Signature of Patient or Guardian Date