Mark Vanicek DDS PC
Margo Schnell DDS
Dentistry for Adults & Children
Williamsburg Village
6101 Village Drive-Suite 102
Lincoln, Nebraska 68516

Date _____

Name _____ *Address* _____

City _____ *State* ___ *Zip* _____ *Home Phone* _____ *Cell Phone* _____

Birth Date _____ *Sex (M/F)* _____ *Social Security #* _____

Employer _____ *Work Phone* _____ *Spouse's Name* _____

Spouse's Employer _____ *Spouse's Social Security #* _____

Name Of Medical Doctor _____ *Phone Number* _____

Person Responsible For Payment _____

Payee's Address (If Other Than Yourself) _____

Dental Insurance Coverage (Y/N) Insurance Company _____

Insured's Name and Employer _____

Insured's Birth Date _____ *Insured's Social Security #* _____

If In College, Are You A Full Time Student? (Y/N) Name Of School _____

Does Your Medical History Include Any Of The Following Conditions?

Yes	*No*		
___	___	1.	*Has Your Doctor Prescribed Antibiotics Before Dental Work for Artificial Joints Or Valves?*
___	___	2.	*Have You Been Diagnosed With A Heart Condition?*
___	___	3.	*Do You Have Anemia, Blood Or Clotting Problems? (Please Circle)*
___	___	4.	*Do You Have Diabetes?*
___	___	5.	*Do You Have Epilepsy?*
___	___	6.	*Do You Have Asthma?*
___	___	7.	*Have You Had Hepatitis A, B, Or C? (Please Circle)*
___	___	8.	*Have You Had Liver, Kidney Or Thyroid Problems? (Please Circle)*
___	___	9.	*Do You Have High Blood Pressure?*
___	___	10.	*Have You Had A Stroke?*
___	___	11.	*Have You Been Diagnosed Hiv+?*
___	___	12.	*Have You Had A Tumor Or Cancer Treatment?*
___	___	13.	*Are You Currently Undergoing Chemotherapy Or Radiation Treatment?*
___	___	14.	*Have You Ever Been Treated For Drug Or Alcohol Dependency?*
___	___	15.	*Have You Ever Received Emotional Or Psychiatric Care?*
___	___	16.	*Are You Currently Pregnant? How Many Months Along?* _____

(Turn Over)

Yes	*No*		
___	___	17.	*List Any Drugs You Are Allergic To* _____
___	___	18.	*List Any Other Allergies Including Food, Metals, Etc.* _____
___	___	19.	*Are You Allergic To Rubber Or Latex Products?*
___	___	20.	*Do You Use Any Tobacco Products? Cigarettes, Chewing Tobacco, Etc.*
___	___	21.	*Are Your Teeth Sensitive To Hot, Cold, Sweets Or Pressure?*
___	___	22.	*Do You Have Bleeding Gums, Loose Teeth Or Bad Breath?*
___	___	23.	*Do You Frequently Get Blisters On Your Lips Or Mouth?*
___	___	24.	*Do You Have Or Ever Had Popping Or Clicking Around The Ears Or TMJ Problems?*
___	___	25.	*Are You Currently Seeing A Physician For Treatment?* *For What?* _____
___	___	26.	*Is There Any Physical Or Mental Handicap We Should Know About?*
___	___	27.	*Are There Any Changes That You Would Like In Your Teeth And Smile?*

_____

How Often Do You Brush? _____ *How Often Do You Floss?* _____

When Was Your Last Dental Exam? _____

List Any Medication You Are Presently Taking _____

_____

In Case Of Emergency, Notify _____ *Phone Number* _____

I Understand That The Information I Provide On This Form Is Essential To Determine My Dental Needs And The Provision Of Dental Treatment. I Understand That If Any Change Occurs In My Health I Am To Report To The Dental Office As Soon As Possible. I Have Read And Understand Each Question, And Have Answered All Of Them Truthfully And To The Best Of My Ability. I Have Discussed My Health History With The Dentist/Hygenist.

If Unable To Keep Any Appointment A 24 Hour Notice Is Required, Otherwise A Fee Will Be Charged For The Time Reserved.

Payment Is Expected When Services Are Rendered.

I Assume Responsibility For This Account. Signature _____

Updated	*Date/Initials* _____	*Date/Initials* _____
	Date/Initials _____	*Date/Initials* _____
	Date/Initials _____	*Date/Initials* _____
	Date/Initials _____	*Date/Initials* _____
	Date/Initials _____	*Date/Initials* _____