JON A. KULESA, D.D.S.

Welcome to our office. Today's Date:_______________

Confidential Patient Information

Patient's Name:____ Martial Status:____________________
Last First Middle

If patient is a minor, parent, or guardian name:____________________ Relationship: ___________________

Minor patients: Age:__________ Birthdate:___________ Sex:_________ Prefers to be Called:____________

Residence:____
Street City State Zip Code

How long at this address:___________ Previous Address:______________________________________
(If less than 3 years) Street City State Zip Code

Mailing Address:____

Home Phone:____________________ Birthdate:_______________ Social Security:__________________

Cell Phone:____________________ Work Phone:_______________ E-Mail:______________________

Employer:__________________________ Occupation:__________________ No. years Employed:______

Spouse's Name:______________________ Birthdate:____________ Social Security:__________________

Cell Phone:____________________ Work Phone:_______________ E-Mail:______________________

Employer:__________________________ Occupation:__________________ No. years Employed:______

Insurance Information

Policy's Holder's Name:________________________________ Relationship to patient:_______________

Insurance Company:__________________ Group No:____________ Member # or Union local #:_________

Insurance Co. Address:____________________________________ Insurance Co. Phone:______________

Policy's Holder's Employer & Address:____

Do you have dual coverage? No Yes If yes:

Policy's Holder's Name:________________________________ Relationship to patient:_______________

Insurance Company:__________________ Group No:____________ Member # or Union local #:_________

Insurance Co. Address:____________________________________ Insurance Co. Phone:______________

Policy's Holder's Employer & Address:____

Emergency Contact Information

Name of nearest relative not living with you:__________________________ Relationship:________________

Phone:_____________________ Complete Address:____

_ _

Whom may we thank for referring you to our office?____

May we leave a message for you at: _______ home, ______ cell phone, ______ answering machine, ______ email?

I understand that where appropriate, credit reports may be obtained.

Signature (Parent's signature if a minor):____

Updates (Date & initial):____

PATIENT MEDICAL HISTORY

Patient Name: _____ Home Phone: _____ Alternate Phone:_____

Physicians Name:_____ Physicians Phone:_____

Preferred Pharmacy: _____ Pharmacy Phone:_____

Please list any medications you are currently taking?_____

Are you currently going any type of medical treatment?_____

Have you had any major operations?_____ **What Kind?**_____

Do you smoke or use tobacco?_____ **Packs per day?**_____

If female please answer the following: Are you taking birth control pills?____ **Are you Pregnant?**_____

Y	N	**Conditions** (please "x")
__	__	Abnormal Bleeding
__	__	Alcohol Abuse
__	__	Allergies
__	__	Anemia
__	__	Angina Pectoris
__	__	Artificial Heart Valve/stents/shunts
__	__	Arthritis, Osteo/Rheumatoid
__	__	Asthma
__	__	Cancer-Chemotherapy
__	__	Congenital Heart Defect
__	__	Diabetes
__	__	Difficulty Breathing
__	__	Donor Organs
__	__	Drug Abuse
__	__	Epilepsy
__	__	Fainting Spells
__	__	Frequent Headaches
__	__	Glaucoma
__	__	HIV + AIDS
__	__	Heart Attack
__	__	Heart Surgery

Y	N	**Conditions**
__	__	Hemophilia
__	__	Hepatitis A, B, C
__	__	High Blood Pressure
__	__	Kidney Problems
__	__	Liver Disease
__	__	Nervous Problems or Disorders
__	__	Osteoporosis
__	__	Pacemaker
__	__	Pain in Jaw Joints
__	__	Psychiatric Problems
__	__	Radiation Therapy
__	__	Recreational Drugs
__	__	Seizures
__	__	Sexually Transmitted Diseases
__	__	Shingles
__	__	Sickle Cell Disease
__	__	Sinus Problems
__	__	Stroke
__	__	Thyroid Problems
__	__	Tuberculosis
__	__	Tumors or Growths
__	__	Ulcers

Have you ever taken the following medication:

Y	N	
__	__	Actonel
__	__	Aredia
__	__	Boniva
__	__	Fosamax
__	__	Zometa
__	__	Other Meds for Bone Density

_____

Y	N	**Allergies**
__	__	Aspirin
__	__	Codeine
__	__	Dental Anesthetics
__	__	Erythromycin
__	__	Jewelry
__	__	Latex
__	__	Metals
__	__	Penicillin
__	__	Tetracycline

Other_____

_____

Is there any diseases, condition, or problem that you think this office should know about that is not covered above?_____

Date	Doctors Signature	BP
		/
		/
		/
		/
		/
		/
		/
		/
		/

OFFICE USE ONLY

Pre-med Required Yes/No Date:_____

Signature Date

If under 18, Parent or Guardian Signature Required