Welcome to the office of Eric Vanek, D.D.S.

Please fill out this patient health record as complete as possible.
The better we communicate, the better we can care for you.

PATIENT INFORMATION

PATIENT'S NAME____NICKNAME:____________________

ADDRESS____BIRTHDATE______/_______/________

CITY____________________________________ZIP_________________MALE☐ FEMALE☐ SINGLE☐ MARRIED☐

EMAIL_____________________________________ DRIVER'S LICENSE#____

HOME PHONE _________________________________WORK/CELL PHONE______________________________________

RESPONSIBLE PARTY INFO (IF MINOR or INSURED SPOUSE, etc)_________________________________INS CARRIER_______

SOCIAL SECURITY #______________________ BIRTHDATE________________EMPLOYER________________________

MEDICAL HEALTH

GENERAL HEALTH : EXCELLENT☐ GOOD☐ FAIR☐ POOR☐

NAME OF PHYSICIAN_________________________PHONE_________________LAST PHYSICAL EXAM_____________

HAVE YOU HAD ANY SERIOUS ILLNESS OR OPERATION?____

HAVE YOU BEEN HOSPITALIZED WITHIN THE PAST FIVE YEARS?____

ARE YOU TAKING MEDICATION NOW? (IF SO, WHAT KIND?)____

____

ARE YOU ALLERGIC TO: PENICILLIN☐ LATEX☐ LOCAL ANESTHETICS☐ CODEINE☐
ANY OTHER MEDICATION?

CHECK (X) IF YOU HAVE BEEN TOLD OR WERE TREATED FOR ANY OF THE FOLLOWING CONDITIONS:

Condition			Condition		
HEART DISEASE	YES☐	NO☐	CANCER - CHEMOTHERAPY	YES☐	NO☐
HEART MRUMUR/MVP	YES☐	NO☐	THYROID DISEASE	YES☐	NO☐
ARTIFICIAL HEART VALVE	YES☐	NO☐	KIDNEY/LIVER DISEASE	YES☐	NO☐
ARTIFICIAL JOINTS	YES☐	NO☐	HEPATITIS	YES☐	NO☐
STROKE	YES☐	NO☐	ASTHMA OR HAY FEVER	YES☐	NO☐
PACEMAKER	YES☐	NO☐	PHEN-PHEN USE	YES☐	NO☐
RHEUMATIC FEVER	YES☐	NO☐	CHEMICAL DEPENDANCY	YES☐	NO☐
HIGH BLOOD PRESSURE	YES☐	NO☐	ARTHRITIS	YES☐	NO☐
ULCERS	YES☐	NO☐	GLAUCOMA	YES☐	NO☐
TUBERCULOSIS OR LUNG DISEASE	YES☐	NO☐	NERVOUS DISORDERS	YES☐	NO☐
DIABETES	YES☐	NO☐	PROLONGED BLEEDING	YES☐	NO☐
EPILEPSY	YES☐	NO☐	FAINTING SPELLS	YES☐	NO☐
CONGENITAL HEART FAILURE	YES☐	NO☐	HIV AND/OR AIDS	YES☐	NO☐
ARE YOU PREGNANT OR TRYING?	YES☐	NO☐	TOBACCO USE	YES☐	NO☐

OTHER NOTES/UPDATES:

AUTHORIZATION FOR DENTAL TREATMENT AND RELEASE OF INFORMATION:

I authorize and give consent to Dr. Eric Vanek and his staff to perform dental treatment, including but not limited to: local anesthesia, analgesia and other such treatment which may be necessary for the above named patient. I also understand that the use of these agents and some procedures embody a certain risk. I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including photos and radiographs and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered.

X____DATE:_______________