Luke Bogdanowicz, DDS & Associates LTD.

Patient Registration

The following confidential information is important for us to know in planning your dental care. Thank you.

Patient Name: _____ Date of Birth: _____ Age: _____

Address: _____ City: _____State: _____Zip:_____

Home Phone: _____Cell Phone: _____Phone Provider:_____

Social Security Number: _____ Email: _____

Account Information

Employer: _____ Position: _____ Work Phone: _____

Spouse's Full Name: _____Date of Birth: _____

Spouse's Employer: _____Position: _____Spouse's Work Phone:_____

Insurance Information

Primary Dental Insurance Company:_____ Policy Number:_____

Name of Policyholder:_____ Social Security Number:_____

Secondary Dental Insurance:_____ Policy Number:_____

Name of Secondary Policyholder:_____ Social Security Number:_____

Person Responsible for Account:_____

Address (if different from patient):_____

In Case of Emergency Please Contact:_____ Phone:_____

Secondary Emergency Contact:_____ Phone:_____

How did you learn about our dental practice? Who can we thank for referring you?_____

All of the information on both sides of this form is correct to the best of my knowledge. I authorize the administration of any medications and the performance of any procedures that are necessary for my dental care. I am aware that I am financially responsible for all dental care provided. I understand that any consideration on my behalf from a dental insurance company or any third party is between myself, my employer, and the insurance company or companies. I further understand and agree that decisions for dental treatment performed are between the doctor and myself, regardless of any dental insurance involvement. In the event the dental fees are not paid as agreed, the undersigned shall pay all reasonable attorney and collection fees. I also authorize my insurance benefits to be assigned to Dr. Bogdanowicz. Any balance over 60 days will accrue an interest rate of 18.99% annually.

Patient Signature: _____ Date: _____

I have received a copy of Dr. Bogdanowicz's HIPAA Private Policy Act.

Patient Signature: _____ Date: _____

Health and Dental History

When did you last visit a dentist? _____

Dentist and location? _____

What was done at that time?_____

Are you satisfied with your past treatment? □ Yes □ No

How long since your last thorough dental examination? _____

How often do you have your teeth cleaned/examined? _____

When were your teeth last cleaned? _____ X-Rays Taken? □ Yes □ No

Are your teeth sensitive to: □ Hot □ Cold □ Sweets □ Pressure □ Chewing □ Other

Do you have any signs of gum disease, bleeding, odor or aches? When/Where?

Has fear kept you from regular dental care? □ Yes □ No

Have you experienced any pain or noise in your jaw joints? □ Yes □ No

Are you aware of any swelling or lumps in your mouth? _____

If you could change your teeth, what would you change? _____

Would you like your teeth:□ Whiter? □ More Cosmetic? □ Tooth Colored Fillings? □ Other _____

Has your physician recommended premedication for any dental treatment? □ Yes □ No

What prompted you to seek dental treatment at this time?_____

Medical History

Name of your physician: _____ Phone Number: _____

Location of your physician: _____

Are you under the care of a physician? □Yes □No-- For what reason?_____

Are you allergic to: □Penicillin □Codeine □Local Anesthetic □Nickel □Mercury □Other_____

Have you ever had a serious illness? □Yes □No-- Please explain _____

What medications and dosages are you presently taking? _____

(Women) Are you pregnant? □ Yes □ No

Please check any and all that apply to your medical history:

□ High Blood Pressure	□ Mental Health Care	□ Tonsillitis
□ Mitral Valve Prolapse	□ Chemical Dependency	□ Sinus Trouble
□ Congenital Heart Defects	□ AIDS/HIV Positive	□ Tuberculosis or Lung Disease
□ Heart Murmur	□ Epilepsy	□ Diabetes
□ Heart Disease	□ Fainting Spells	□ Thyroid Problems
□ Circulatory Problems	□ Tumors/Cancer	□ Kidney Problems
□ Rheumatic Fever	□ Radiation Therapy	□ Jaundice
□ Blood Transfusion	□ Arthritis	□ Hepatitis
□ Stroke	□ Asthma or Hay Fever	□ Ulcers
□ Anemia	□ Other _____	□ Other _____
□ Joint Implant	□ Other _____	□ Other _____