



KURT R. KWIATKOWSKI DDS, SC
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ARTISTRY • INTEGRITY • PASSION

WWW.THEFUTUREOFDENTISTRY.COM
Tel: 262-377-0852

1200 SEVENTEENTH AVENUE
GRAFTON, WISCONSIN 53024

PATIENT INFORMATION

Date: _____ NEW PATIENT UPDATE

Patient: _____

LAST FIRST MI PREFERRED TITLE

MALE FEMALE CHILD* STUDENT** SINGLE MARRIED DIVORCED WIDOWED

*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S) BELOW: _____
PARENT/GUARDIAN NAME(S)

**IF STUDENT, PLEASE COMPLETE: FULL-TIME PART-TIME
SCHOOL/LOCATION _____

Patient Date of Birth: _____ Patient SSN: _____

Address: _____
ADDRESS LINE 1
ADDRESS LINE 2
CITY ST ZIP CODE

E-Mail: _____

HOME: _____
CELL: _____
OTHER: _____
PAGER: _____
FAX: _____

Referral? Yes No Referred by: _____

MEDICAL HISTORY UPDATES

GENERAL HEALTH: EXCELLENT GOOD FAIR POOR

Would you like to have a VisiLite oral cancer screening? Y N

**Note: Some insurance plans do not cover this service; please check your plan documents for details.*

- Y N Under a physician's care now?
- Y N Any hospitalization in the past 5 years? _____
- Y N Any serious illnesses/surgeries? _____
- Y N Use tobacco in any form? If Yes, Type: _____
- Y N Is pre-medication required before dental visits due to heart condition or artificial joint?

FEMALE PATIENTS: Y N Currently nursing? Y N Currently pregnant? Due Date: _____

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? Y N
If yes, please describe: _____

Is there anything important about your medical condition we have not asked? Y N If yes, please describe: _____



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ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): NONE

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> ACID REFLUX | <input type="checkbox"/> BULIMIA | <input type="checkbox"/> HEARING PROBLEMS | <input type="checkbox"/> PSYCHIATRIC TREATMENT |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> CANCER/MALIGNANCY | <input type="checkbox"/> HEART ATTACK | <input type="checkbox"/> RADIATION/CHEMO |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> CEREBRAL PALSY | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> RESPIRATORY DISEASE |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> CHEMICAL DEPENDENCY | <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> RHEUMATIC FEVER |
| <input type="checkbox"/> ANOREXIA | <input type="checkbox"/> CHICKEN POX | <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> SINUS PROBLEMS |
| <input type="checkbox"/> ANXIETY | <input type="checkbox"/> CONVULSIONS | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> ARTIFICIAL HEART VALVE | <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> THYROID CONDITION |
| <input type="checkbox"/> ARTIFICIAL JOINTS | <input type="checkbox"/> DIABETES | <input type="checkbox"/> LIVER PROBLEMS | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> DIZZINESS/FAINTING | <input type="checkbox"/> MITRAL VALVE PROLAPSE | <input type="checkbox"/> ULCERS |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> EPILEPSY/SEIZURES | <input type="checkbox"/> MONONUCLEOSIS | <input type="checkbox"/> VENEREAL DISEASE |
| <input type="checkbox"/> AUTISM/ASPERGER'S | <input type="checkbox"/> FREQUENT EAR INFECTIONS | <input type="checkbox"/> PACEMAKER | |
| <input type="checkbox"/> BLEEDING DISORDER | <input type="checkbox"/> FREQUENT HEADACHES | <input type="checkbox"/> OTHER – PLEASE LIST: | |

ALLERGIES/ALLERGIC REACTIONS

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

- | | | | | |
|--|----------------------------------|---|---|-------------------------------|
| <input type="checkbox"/> ASPIRIN | <input type="checkbox"/> CODEINE | <input type="checkbox"/> LACTOSE INTOLERANCE | <input type="checkbox"/> SLEEPING PILLS | <input type="checkbox"/> NONE |
| <input type="checkbox"/> ANESTHETIC – LOCAL | <input type="checkbox"/> DAIRY | <input type="checkbox"/> METAL SENSITIVITY | <input type="checkbox"/> SULFA DRUGS | |
| <input type="checkbox"/> BARBITURATES | <input type="checkbox"/> LATEX | <input type="checkbox"/> NITROUS OXIDE SEDATION | <input type="checkbox"/> PENICILLIN/OTHER ANTIBIOTICS | |
| <input type="checkbox"/> OTHER – PLEASE LIST | | | | |

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY):

NONE

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> ANTIBIOTICS/SULFA DRUGS | <input type="checkbox"/> ANTIHISTAMINES/ALLERGY | <input type="checkbox"/> DAILY ASPIRIN | <input type="checkbox"/> BLOOD PRESSURE MEDICATIONS |
| <input type="checkbox"/> BLOOD THINNERS | <input type="checkbox"/> CANCER/CHEMO MEDICATIONS | <input type="checkbox"/> CORTISONE/STEROIDS | <input type="checkbox"/> HEART MEDICATION/DIGITALIS |
| <input type="checkbox"/> INSULIN | <input type="checkbox"/> NITROGLYCERIN | <input type="checkbox"/> ORAL CONTRACEPTIVES | <input type="checkbox"/> OSTEOPOROSIS MEDICATIONS |
| <input type="checkbox"/> RECREATIONAL DRUGS | <input type="checkbox"/> THYROID MEDICATIONS | <input type="checkbox"/> TRANQUILIZERS | <input type="checkbox"/> OTHER DIABETIC MEDICATIONS |
| <input type="checkbox"/> OTC DRUGS/ MEDICATIONS | <input type="checkbox"/> OTHER (PLEASE LIST BELOW) | | |

(PLEASE LIST BELOW)

DRUG NAME	DOSAGE	REASON PRESCRIBED

PATIENT CONSENT

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status of if my medication changes, I shall inform the dentist and staff at the next appointment without fail.

Signature:

DATE:

RELATIONSHIP TO PATIENT: ADULT PATIENT PARENT GUARDIAN OTHER



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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Updated 2013

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Name:

Date:

RELATIONSHIP TO PATIENT: SELF PARENT GUARDIAN OTHER(PLEASE EXPLAIN)

Please list any dependent children under the age of 18 also covered by this acknowledgement:

I give permission for the following communications to be used by Dr. Kurt Kwiatkowski DDS, SC:

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> Cell phone: | <input type="checkbox"/> Text Message reminders permitted |
| <input type="checkbox"/> Home phone | <input type="checkbox"/> Work <input type="checkbox"/> E-Mail: |

I give permission for Dr. Kurt Kwiatkowski DDS, SC to disclose their identity when calling; to anyone who may answer my phone. Y N Other (Please explain)

I grant permission for Dr. Kurt Kwiatkowski DDS, SC to leave a message on:

- | | |
|---|---|
| <input type="checkbox"/> Home phone | <input type="checkbox"/> Work Phone |
| <input type="checkbox"/> Cell Phone | <input type="checkbox"/> With any person who may answer when calling the home or cell phone |
| <input type="checkbox"/> None of the above (Please explain) | |

I would like the following person(s) to have access to my personal information including but not limited to appointments, treatment, and billing of myself and any dependent children listed above:

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- The patient refused to sign
- Communication barriers
- Emergency situation
- Other – please list: