Richard Volker, D.D.S. • 2103 Sawyer Drive • Niagara Falls, NY 14304 • 716 - 283-5800

PATIENT INFORMATION

Patient's Name: Last _____ First _____ Middle Initial _____ Sex: ❑ M ❑ F Birthdate _____ Age _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Place of employment of patient, or parent if minor _____ Email _____

Marital Status _____ Spouse's Name _____

If minor, Father's Name _____ Mother's Name _____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

FINANCIALLY RESPONSIBLE PARTY

Name-Last _____ First _____ Phone _____

Address _____ SS # _____

Dental Insurance Information (Primary Carrier)

Insured's Name _____

Insurance Co. _____

Insured's Employer _____

SS # _____ Date of Birth _____

ID # _____ Group # _____

If you have secondary dental insurance coverage, complete this:

Insured's Name _____

Insurance Co. _____

Insured's Employer _____

SS # _____ Date of Birth _____

ID # _____ Group # _____

DRUGS AND MEDICATION Are you taking any over the counter drugs or prescription medication? YES NO If so, please list:

Name of drug or medication	Condition it is taken for	Name of drug or medication	Condition it is taken for
(1)	(1)	(4)	(4)
(2)	(2)	(5)	(5)
(3)	(3)	(6)	(6)

DENTAL HISTORY	YES	NO
HOW LONG SINCE you have seen a Dentist?		
Last COMPLETE Dental Exam, Date:		
Last FULL MOUTH X-RAYS, Date: (14 small Films or Panoramic)		
Are you having PROBLEMS now? What?		
Do you wear Dentures? (Partial OR Full?)	❑	❑
Are you UNHAPPY with your dentures?	❑	❑
Would you like to know more about PERMANENT REPLACEMENTS	❑	❑
Have you had PERIODONTAL (GUM) treatments?	❑	❑
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)	❑	❑
Are you UNHAPPY with the APPEARANCE of your teeth?	❑	❑
Are you aware of GRINDING or CLENCHING your teeth?	❑	❑
Do you have HEADACHES, EARACHES, or NECK PAINS?	❑	❑
Have you worn BRACES on your teeth? (ORTHODONTICS)	❑	❑
Do you regularly use dental floss?	❑	❑
Name of Previous Dentist:		
City: State:		
Reason for this visit :		

FAMILY PHYSICIAN

Physician's Name:

Phone:

ARE YOU **ALLERGIC** TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS OR SUBSTANCES?

Aspirin	Local Anesthetic	Erythromycin	Latex
Darvon	Codeine	Penicillin	Sulfa

Other: _____

MEDICAL HISTORY	YES	NO
Do you have any CURRENT HEALTH PROBLEMS?	❑	❑
Are you under a PHYSICIAN'S CARE now?	❑	❑
For What?		
Do you take aspirin or blood thinner?	❑	❑
Are you PREGNANT?	❑	❑
Do you SMOKE?	❑	❑
Do you have a pacemaker?	❑	❑
Have you had any surgeries?	❑	❑
Do you have any pins or screws?	❑	❑

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR PRESENTLY HAVE:

A.I.D.S./A.R.C./HIV Pos.	Cosmetic Surgery	High Blood Pressure
Alcoholism	Diabetes	Kidney Trouble
Allergies or Hives	Drug Addiction	Leukemia
Alzheimer's/Dementia	Emphysema	Liver Disease
Anemia	Epilepsy or Seizures	Mitral Valve Prolapse
Angina Pectoris	Fever Blisters	Multiple Sclorosis
Arthritis	Glaucoma	Nervousness
Artificial Heart Valve	Hay Fever	Pain in Jaw Joints
Artificial Joints (Hip, Knee)	Heart Disease or Attack	Parkinson's Disease
Asthma	Heart Murmur	Psychiatric Treatment
Blood Transfusion	Heart Pacemaker	Radiation Treatment
Bruise Easily	Heart Surgery	Rheumatic Fever
Cancer	Hemophilia	Sinus Trouble
Chemotherapy	(Bleeding Problems)	Stroke
Cholesterol	Hepatitis A (infectious)	Thyroid Disease
Congenital Heart Lesions	Hepatitis B (serum)	Tuberculosis (TB)
Cortisone Medicine	Hepatitis C	Ulcers
		Venereal Disease

Other: _____

PATIENT Signature (Parent of Child) _____ Date: _____