



David Baranowski, DDS
 422 N Ivey Ave, Siler City, NC, 27344
 Phone: 919-663-3341 Fax: 919-663-2091
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PATIENT INFORMATION

First Name: _____ Last Name: _____ Middle Initial: _____
 Preferred Name: _____ Address: _____
 City, State, Zip: _____ Gender: Male Female Birth Date: _____
 Cell Phone #: _____ Home Phone #: _____ Work Phone #: _____
 E-Mail: _____ SSN: _____ Marital Status: Married Single Divorced
 Emergency Contact (Name & Number): _____ Relationship to Patient: _____

INSURANCE INFORMATION

No Insurance Name Same as Above Name of Insured: _____ Birth Date: _____
 Relationship to Insured: Self Spouse Child Subscriber ID #: _____ Group #: _____
 Group Name: _____ Insurance Company: _____ Phone #: _____

MEDICAL INFORMATION

Are you under a physician's care now? Yes No If yes: _____
 Have you ever been hospitalized or had a major operation? Yes No If yes: _____
 Have you ever had a serious head or neck injury? Yes No If yes: _____
 Are you taking any medications, pills or drugs? Yes No If yes: _____
 Do you take, or have you taken, Phен-Fen or Redux? Yes No If yes: _____
 Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes: _____
 Are you on a special diet? Yes No
 Do you use tobacco? Yes No
 Do you use controlled substances? Yes No If yes: _____

WOMEN ONLY: Are you...
Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives

Are you allergic to any of the following?
Aspirin Penicillin Codeine Acrylic Metal Latex Sulfa Drugs Local Anesthetics
Other? _____

Do you have, or have you had, any of the following?			
AIDS/HIV Positive <input type="checkbox"/> Yes <input type="checkbox"/> No	Cortisone Medicine <input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia <input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatments <input type="checkbox"/> Yes <input type="checkbox"/> No
Alzheimer's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis A <input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Weight Loss <input type="checkbox"/> Yes <input type="checkbox"/> No
Anaphylaxis <input type="checkbox"/> Yes <input type="checkbox"/> No	Drug Addiction <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis B or C <input type="checkbox"/> Yes <input type="checkbox"/> No	Renal Dialysis <input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Easily Winded <input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Angina <input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatism <input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis/Gout <input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy or Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve <input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No	Hives or Rash <input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles <input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joint <input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Thirst <input type="checkbox"/> Yes <input type="checkbox"/> No	Hypoglycemic <input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting Spells/Dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No	Irregular Heart Beat <input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Cough <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Spina Bifida <input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No	Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach/Intestinal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Breathing Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No



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Continued...Do you have, or have you had, any of the following?			
Bruise Easily	<input type="checkbox"/> Yes <input type="checkbox"/> No	Genital Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pains	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Attack/Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cold Sores/Fever Blisters	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No
Convulsions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Trouble/Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Pain in Jaw Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Parathyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Swelling of Limbs	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Tumors or Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Yellow Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you ever had any serious illness not listed above? Yes No If yes: _____

DENTAL HISTORY

Have you had any serious trouble associated with any previous dental treatment? Yes No If yes: _____

Are you wearing removable dental appliances? Yes No If yes: _____

Chief Dental Complaint: _____

I acknowledge that I have received and reviewed the HIPAA policy.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth that have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient, Parent or Guardian

Date