Mark R. Byladek, DMD | 609.397.8833

RiverValleyDental

PATIENT REGISTRATION & DENTAL HISTORY

PATIENT INFORMATION

Patient Name *Preffered*

Address

City, State, ZIP

Home Phone # *Cell Phone #*

Birthdate *SSN*

E-mail Address

Sex *Male* ☐ *Female* ☐

Status *Single* ☐ *Married* ☐ *Life-Partner* ☐ *Widowed* ☐

IN CASE OF EMERGENCY, PLEASE CONTACT

Referred by

Date of Last Dental Exam

Date of Last Dental X-Rays

Previous Dentist

Address

Phone #

DENTAL INSURANCE

Insurance CO *Phone #*

Address

City, State, ZIP

Name of Subscriber

Subscriber ID *Group #*

Subscriber Employer

Subscriber Birthdate *SSN*

Name of Secondary Subscriber

Insurance CO *Phone #*

Address

City, State, ZIP

Subscriber ID # *Group #*

Subscriber Employer

Subscriber Birthdate *SSN*

I certify that I and/or my dependents have insurance coverage and assign directly to Dr. Mark Bydalek all insurance benefits if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Resonsible Party Signature *Date*

PLEASE CHECK YES OR NO IF YOU HAVE ANY OF THE FOLLOWING

Bad Breath	*YES* ☐	*NO* ☐	*Cigarette, Pipe, or Cigar Smoking*	*YES* ☐	*NO* ☐
Bleeding Gums	*YES* ☐	*NO* ☐	*How long?* _____ *How much?* _____		
Dry Mouth	*YES* ☐	*NO* ☐	*Would you like information on quitting smoking?*		
Food Collection Between Teeth	*YES* ☐	*NO* ☐		*YES* ☐	*NO* ☐
Tooth Sensitivity	*YES* ☐	*NO* ☐	*History of Periodontal Treatment*	*YES* ☐	*NO* ☐
Sores/Growths in Mouth	*YES* ☐	*NO* ☐	*History of Orthodontic Treatment*	*YES* ☐	*NO* ☐
Loose Teeth	*YES* ☐	*NO* ☐			
Clicking/Popping in Jaw	*YES* ☐	*NO* ☐	*How often do you brush?* _____		
Grinding Teeth	*YES* ☐	*NO* ☐	*How often do you floss?* _____		

HEALTH HISTORY

BLOOD

Anemia YES ☐ NO ☐
Blood Transfusion YES ☐ NO ☐
*Date*_____
Bleeding abnormally with extractions or surgery YES ☐ NO ☐
Blood Disease YES ☐ NO ☐

BONE/MUSCLES

Arthritis/Rheumatism YES ☐ NO ☐
Artificial Joint YES ☐ NO ☐
*Surgery Date:*_____

HEART

Artificial Heart Valve YES ☐ NO ☐
Congenital Heart Disease YES ☐ NO ☐
Heart Murmur YES ☐ NO ☐
Mitral Valve Prolapse YES ☐ NO ☐
Heart Attack YES ☐ NO ☐
High Blood Pressure YES ☐ NO ☐
Low Blood Pressure YES ☐ NO ☐
Pacemaker YES ☐ NO ☐
*Date placed*_____
Rheumatic Fever YES ☐ NO ☐
Shortness of Breath YES ☐ NO ☐
Swelling of Ankles YES ☐ NO ☐

NERVOUS SYSTEM

Stroke YES ☐ NO ☐
Epilepsy/Seizures YES ☐ NO ☐
Fainting/Dizziness YES ☐ NO ☐
Anxiety YES ☐ NO ☐
Bipolar Disorder YES ☐ NO ☐
Schizophrenia YES ☐ NO ☐
Mood Disorder YES ☐ NO ☐
Frequent Headaches/Migraines YES ☐ NO ☐

RESPIRATORY SYSTEM

Asthma YES ☐ NO ☐
Tuberculosis YES ☐ NO ☐
Emphysema YES ☐ NO ☐

DIGESTIVE SYSTEM

Hepatitis YES ☐ NO ☐
*Type*_____
Jaundice YES ☐ NO ☐
Hoarseness YES ☐ NO ☐
IBS YES ☐ NO ☐
Crohn's Disease YES ☐ NO ☐
Ulcerative Colotis YES ☐ NO ☐
Kidney Disease YES ☐ NO ☐

ENDOCRINE SYSTEM

Diabetes YES ☐ NO ☐
*Type*_____
Thyroid Problems YES ☐ NO ☐

GENERAL

Unexpected Weight Loss YES ☐ NO ☐
Hearing Loss YES ☐ NO ☐
Tire Easily YES ☐ NO ☐
Nose Bleeds YES ☐ NO ☐
Sinus Trouble YES ☐ NO ☐
Glaucoma YES ☐ NO ☐

OTHER

Cancer YES ☐ NO ☐
*Type*_____
Tumor or Growth YES ☐ NO ☐
Chemotherapy YES ☐ NO ☐
*Date*_____
Radiation Treatment YES ☐ NO ☐
*Date*_____
Herpes YES ☐ NO ☐
*Type*_____
Human Papilloma Virus YES ☐ NO ☐
HIV YES ☐ NO ☐
AIDS YES ☐ NO ☐
History of Alcohol/Drug Abuse YES ☐ NO ☐
Do you need to Pre-Medicate? YES ☐ NO ☐
*Why?*_____
*If so, what with?*_____

WOMEN:
Are you pregnant? YES ☐ NO ☐
*Due Date:*_____
Are you nursing? YES ☐ NO ☐
Hormone Replacement YES ☐ NO ☐

MEDICATIONS & ALLERGIES

List prescribed and over the counter Medications and Supplements you are currently taking:

_____
_____
_____
_____

Physician's Name _____
*Phone*_____

☐ *Aspirin/Ibuprofen*
☐ *Barbiturates (sleeping pills)*
☐ *Codeine*
☐ *Novocaine & Dental Anasthetic*
☐ *Penicillin*
☐ *Sulfa*
☐ *Latex*
☐ *Other*_____

*If you responded "YES" to any of the above, please explain:*_____

*Do you have any other conditions/health concerns not listen above?*_____

I ACCEPT RESPONSIBLITY THAT ALL THE INFORMATION ABOVE IS CORRECT _____
SIGNATURE *DATE*