WILLIAM J. HOLEVAS D.D.S., LTD
LIFE CHANGING DENTISTRY

Patient Information

Date: ______________

Patient's Name: ____D.O.B____________ Gender F M
Last First MI

Address: ____
Street City State Zip

Home #: _________________________Work #: ________________________Cell #: __________________________

SS#:_____________________________________ E-mail: ____

If patient is minor, name of parent/guardian: ____

Who may we thank for referring you to our office? ____

Financially Responsible Party Information (if same as above, write "same")

Name: ____D.O.B ______________________
Last First MI

Address: ____
Street City State Zip

Home #:_____________________Work #:_________________Cell #:_______________________________________

SS#:_____________________________ Relationship to patient ____

Employer: ____________________________ Occupation: ______________________________Yrs. Employed: _____

I understand that I am responsible for payment of all services and that payment is due at time of service unless other financial arrangements have been agreed upon prior to the date of dental treatment. I also authorize dental insurance benefits to be paid to Dr. William J. Holevas.

Signature: ____ Date: ___________________

Emergency Information

Who should we contact in case of an emergency?

___

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Name Phone # Relationship

(Over Please)

Dental History

Are you having any discomfort at this time? ________If yes, please describe___________________________________
Date of last dental visit: ___________ Procedures performed: ____
How often do you visit the dentist? ________Have you lost any teeth? ____ Any complications with extraction? _____
describe: _________________________________ have any teeth been replaced by a: fixed bridge____ removable partial ___ denture ___. Are your teeth sensitive to: cold _____ hot _____ sweet _____ sour _____ pressure ____?
How often do you brush your teeth? ________ Do your gums bleed? _____ When? ______Have you had periodontal treatment? ______ When? ______________Does food wedge between your teeth? ______ Where? _______________
Have you had your teeth straightened? _____ When? ________________Do you grind or clench your teeth? ____
When? ______________Do you have pain in or around your ears? ______ Do you hear popping, clicking or snapping noises when you chew? ______Do you have any swelling or lumps in your mouth? ____Do you have any fears associated with dentistry? _____ Explain __________________How do you feel about your teeth? ______________
Is there anything you'd like to change about them? ____

Medical History

Physician's Name __________________________ Phone # ___________________Date of last physical exam_______

Y	N	Condition	Y	N	Condition	Y	N	Condition
		Frequent Headaches/Migraines			Arteriosclerosis			Emphysema
		Allergies			Angina Pectoris			Tuberculosis
		Sinus Problems			Heart Attack			Any Hepatitis
		Thyroid Problems			Artificial Heart Valve			HPV
		Kidney Problems			Pace Maker			Herpes
		Diabetes			Taken Fen-Phen			HIV+ or AIDS
		Gastric Ulcers/Stomach Problems			Rheumatic Fever			Alcohol Abuse
		Anemia			Stroke			Drug Abuse
		Abnormal Bleeding			Stress or Depression			Malignancies
		Blood Transfusion			Epilepsy			Chemo/Radiotherapy
		Any Other Blood Disorder			Bipolar Disorder			Cosmetic or other surgeries
		Congenital Heart Diseases			Sleep Apnea/Snoring			Pain in Jaw Joints
		Mitral Valve Prolapsed			CPAP			Osteoporosis
		Heart Murmur			Oral Appliance			Arthritis
		Low Blood Pressure			COPD			Rheumatoid Arthritis
		High Blood Pressure			Asthma			Replacement Knee, Hip, etc
		High Cholesterol Levels			Pneumonia			

Y	N	Allergies	Y	N	Allergies	Y	N	If female please answer the following
		Aspirin			Latex			Are you taking Birth Control Pills?
		Codeine			Metals			Are you Pregnant? If yes, # of weeks

		Dental Anesthetics			Penicillin			Are you nursing?
		Erythromycin			Tetracycline	**Y**	**N**	**Please answer the following:**
		Jewelry			Other:			Do you smoke or use tobacco?

Please describe any current medical treatment, impending operations or any other information that may possibly affect your dental treatment: ____

Please list any medications that you are currently taking: ____
____

Signature: ____ Date ______________________________

(If under 18, Parent or Guardian Signature Required)