



# Chesterfield Laser Dental

Peter M. Carlin, D.D.S. Nicholas G. Schesnok, D.D.S.

Jeanine Lukowski, RDH; Heather St. John, RDH; Lisa Luzynski, RDH; Courtney Tessmer, RDH

Patient Name Last: \_\_\_\_\_ First: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Are you having any discomfort, pain, or aware of any dental problems? \_\_\_\_\_

Do you have dental implants? \_\_\_\_\_ Would you like to know more about dental implants? \_\_\_\_\_

Are you happy with the appearance of your teeth? If no, why? \_\_\_\_\_

How long has it been since you last visited a dental office? \_\_\_\_\_

How did you find out about our office? If referred, by whom? \_\_\_\_\_

Bad reaction/troubles with anesthesia? \_\_\_\_\_

Do you have dental insurance? \_\_\_\_\_ Name of Insurance \_\_\_\_\_ Your S.S.# \_\_\_\_\_

Policy holder: \_\_\_\_\_ Employer: \_\_\_\_\_ ID# \_\_\_\_\_ Group#: \_\_\_\_\_

If applicable, spouses dental insurance: \_\_\_\_\_ Their S.S.# \_\_\_\_\_

## HEALTH HISTORY

Your Physician's Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Has there been any problems in your general health within the past 5 years? \_\_\_\_\_

If so, what was the problem? \_\_\_\_\_

Recent Hospitalization / Surgery / Injury? \_\_\_\_\_

The date of your last medical check-up: \_\_\_\_\_ Are you under a physicians care now? \_\_\_\_\_

If so, for what? \_\_\_\_\_

What tablets, pills or liquids do you take? (that includes, aspirins, vitamins, tonics, etc.) \_\_\_\_\_

## DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS:

	YES	NO		YES	NO
Stomach/Intestinal . . . . .	_____	_____	Neurological problems (Brain)? . . . . .	_____	_____
Skin problems? . . . . .	_____	_____	Are you HIV positive? . . . . .	_____	_____
Thyroid . . . . .	_____	_____	Have you had cancer? . . . . .	_____	_____
Heart trouble, heart attack, high blood pressure, stroke . . . . .	_____	_____	Cancer of the head & neck? . . . . .	_____	_____
Heart Pacemaker or Stent . . . . .	_____	_____	History of alcohol or drug abuse . . . . .	_____	_____
Rheumatic fever, rheumatic heart disease . . . . .	_____	_____	Do you have any special needs? . . . . .	_____	_____
Heart murmur, mitral valve prolapse, artificial valve . . . . .	_____	_____	<b>SENSITIVE OR ALLERGIC TO:</b>		
Artificial joints . . . . .	_____	_____	Penicillin . . . . .	_____	_____
Abnormal bleeding, prolonged healing, bruises easily . . . . .	_____	_____	Sulfa . . . . .	_____	_____
Blood disorders, anemia, leukemia . . . . .	_____	_____	Codeine . . . . .	_____	_____
Asthma, hay fever, tuberculosis . . . . .	_____	_____	Aspirin . . . . .	_____	_____
Fainting spells, seizures . . . . .	_____	_____	Anesthetics (Dental) . . . . .	_____	_____
Hepatitis, jaundice, liver disease . . . . .	_____	_____	Latex . . . . .	_____	_____
Muscle, bone, joint problems? Arthritis . . . . .	_____	_____	Other allergies . . . . .	_____	_____
Kidney troubles (or urinary) . . . . .	_____	_____	Do you have any disease, condition, or problem not listed that you think the doctor should know about?		
Breathing/respiratory ailments (problems) . . . . .	_____	_____	_____		
Diabetes . . . . .	_____	_____	<b>WOMEN: Are you pregnant? . . . . .</b>	_____	_____
			Do you take birth control pills? . . . . .	_____	_____



## Authorization for Release of Information to Family Members

Patient Name	Date of Birth
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Many of our patients allow family members such as their spouse, parents or others to call and request dental or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your dental or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Dr. Carlin and Dr. Schesnuk Dental Office to release my medical and/or billing information to the following individual(s):

1. \_\_\_\_\_ Relation to Patient: \_\_\_\_\_
2. \_\_\_\_\_ Relation to Patient: \_\_\_\_\_
3. \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

### Authorization to Leave Detailed Messages

Occasionally it is necessary for the staff of Dr. Carlin and Dr. Schesnuk Dental Office to leave messages for patients. The purpose of these messages is to notify the patient that we would like to discuss treatment needs, billing purposes or to ask a patient to call back regarding an issue or concern. To expedite the receipt of the needed information, please indicate below if you would like to give consent to leave detailed messages.

#### Please mark your preference below:

\_\_\_\_\_ I authorize Dr. Carlin and Dr. Schesnuk Dental Office to leave detailed voicemails.

\_\_\_\_\_ This is the phone number I would like messages left: \_\_\_\_\_

\_\_\_\_\_ I authorize Dr. Carlin and Dr. Schesnuk Dental Office to send detailed emails.

\_\_\_\_\_ This is the email address I would like messages sent: \_\_\_\_\_

\_\_\_\_\_ I do not want any detailed messages left on voicemail or sent via email.

#### Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above authorized recipient or voicemail or email is no longer protected by federal or state law and may be subject to redisclosure by the above recipient or someone who has access to your voicemail or email.

You have the right to revoke this consent in writing.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Chesterfield Oaks Dental Group

Peter M. Carlin, D.D.S.

Nicholas G. Schesnuk, D.D.S.

Jeanine Lukowski, RDH; Heather St. John, RDH; Lisa Luzynski, RDH; Courtney Tessmer, RDH

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Phone 586 · 949 · 0611 · Fax 586 · 949 · 1714

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Phone/Cell # \_\_\_\_\_

Father's Name: \_\_\_\_\_ Phone/Cell # \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code \_\_\_\_\_

Does your child have dental insurance? If so, insurance carrier? \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Policy Holder's Employer: \_\_\_\_\_ Policy Holder's SS# or Member ID \_\_\_\_\_

## PATIENT MEDICAL HEALTH HISTORY

Is this your child's first visit to the dentist? YES NO

If previously seen by a dentist, how long has it been since their last visit? \_\_\_\_\_

Is your child under the care of a physician or family doctor for a special problem? \_\_\_\_\_

Is your child taking any medicine? If so, please list: \_\_\_\_\_

Does your child have any physical, mental or emotional disabilities? \_\_\_\_\_

Has your child ever had any of the following? Please check appropriate spaces:

Rheumatic Fever / Heart Murmur

Heart Trouble

Diabetes

Asthma or Hayfever

Sickle Cell (trait or anemia)

Bleeding Disorder

Jaundice or Hepatitis

Convulsion or Epileptic Seizures

Tuberculosis

Kidney or Liver Problems

Thyroid Gland Problem

Are there any other medical problems? \_\_\_\_\_

Has your child ever experienced an unusual reaction to any of the following medicines?

Aspirin

Tranquilizers

Dental Local Anesthetics

Penicillin

Nitrous-Oxide/Oxygen

Other Allergies \_\_\_\_\_

Are you aware of any dental problems? \_\_\_\_\_

Do you supervise your child's toothbrushing? YES NO

