

# NEW ALBANY FAMILY DENTISTRY TIMOTHY J. BACKIEWICZ, D.D.S., INC.

21 N. HIGH STREET  
NEW ALBANY, OHIO 43054  
TELEPHONE (614) 855-0202

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_

I like to be called/Nickname: \_\_\_\_\_

Home Address: \_\_\_\_\_  
\_\_\_\_\_

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

E-mail Address: \_\_\_\_\_

Birthday: \_\_\_\_\_  Male  Female

Social Security#: \_\_\_\_\_

Single  Married  Widowed  Divorced

How did you find our office?

Phone Book  Advertisement  Insurance Co.

Drive-By/Sign  Referral  Other

If Referred, by whom? \_\_\_\_\_

## DENTAL INSURANCE

Do you have Dental Insurance?  Y  N

Name of Insurance Co.: \_\_\_\_\_

Group # / Group Name: \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_

Insurance Coverage is through: Policy Holder?

Self  Spouse  Parent  Other

If other, explain: \_\_\_\_\_

Policy Holder's Full Name \_\_\_\_\_

Policy Holder's Social Security #: \_\_\_\_\_

Policy Holder's Birthday: \_\_\_\_\_

Policy Holder's Employer: \_\_\_\_\_

Do you have any other Dental Insurance?  Y  N

Name of Insurance Co. #2: \_\_\_\_\_

Group # / Group Name: \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_

Your Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Work Address: \_\_\_\_\_  
\_\_\_\_\_

Work Phone: \_\_\_\_\_ Ext.#: \_\_\_\_\_

Do you or does your employer object to phone calls at work to discuss dental matters?  Y  N

When is the best time to reach you?

Morning  Afternoon  Evenings

Where is the better place to reach you?

Home  Work

Specific Days?: \_\_\_\_\_

### In case of emergency, who should be notified?

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_

## DENTAL HISTORY

Why have you come to the dentist today?  
\_\_\_\_\_  
\_\_\_\_\_

Approximate date of your last dental visit: \_\_\_\_\_

Did you have X-rays taken?  Yes  No

Are you currently in pain?  Yes  No

Do you think you have cavities?  Yes  No

Do your gums ever bleed?  Yes  No

Do you think you have gum disease?  Yes  No

Do you feel that you have bad breath?  Yes  No

Does your jaw ever ache?  Yes  No

Does your jaw ever "pop" or "lock" position?  
 Yes  No

Do you grind your teeth at night or during the day?  
 Yes  No

Do you experience several headaches per week?  
 Yes  No

Are you interested in cosmetic dentistry or bleaching?  
 Yes  No

You current dental health is:  Good  Fair  Poor

# MEDICAL HISTORY

## Are you allergic to any of the following drugs:

Penicillin  Y  N Codeine  Y  N

Sulfa Drugs  Y  N Aspirin  Y  N

Tetracycline  Y  N Novocaine  Y  N  
(Dental Anesthetic)

Are you allergic to any DRUG not listed above:

Y  N If yes, please list: \_\_\_\_\_

Are you currently taking any medications

prescribed by a Physician?  Yes  No

If yes, please list \_\_\_\_\_

\_\_\_\_\_

Do you have a personal Physician?  Yes  No

Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

Approximate last visit: \_\_\_\_\_

Your current PHYSICAL health is?

Good  Fair  Poor

Have you had any serious medical

problems in the past 5 years?  Yes  No

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Do you smoke?  Yes  No

Do you chew tobacco?  Yes  No

For women: Are you pregnant?  Yes  No

## Do you or have you ever had any of the following diseases or medical problems.

Y N Heart Attack/Stroke Y N Cancer/Chemotherapy

Y N Heart Murmur/  
Rheumatic Fever Y N HIV & AIDS

Y N Heart Surgery/Pacemaker Y N Asthma

Y N Artificial Heart Valve Y N Tuberculosis (TB)

Y N Mitral Valve Prolapse Y N Sickle Cell Disease

Y N Anemia Y N Psychiatric Problems

Y N Hepatitis Y N Kidney Problems

Y N High Blood Pressure Y N Liver Problems

Y N Low Blood Pressure Y N Diabetes

Y N Epilepsy/Seizures/  
Fainting Spells Y N Bowel Problems

Y N Back Pain

Y N Hemophilia/Bleeding  
Disorder Y N Neck Pain

Y N Severe Headaches

Y N Joint Replacement/  
i.e. Knee, Hip Y N Sinus Problems

Y N Brain Aneurism Y N Fever Blisters

Have you ever experienced any disease or medical  
problem that is not listed above?  Yes  No

If yes, please list: \_\_\_\_\_

\_\_\_\_\_

**Have you ever been instructed to take antibiotics**

**prior to your Dental appointments due to**

**(history of) Mitral Valve Prolapse, Rheumatic**

**Fever, or Joint Replacement?**  Yes  No

OFFICE USE ONLY Doctor's Comments: \_\_\_\_\_

\_\_\_\_\_

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in strictest confidence and that it is my responsibility to inform this office of any changes in my medical status.

Signature

Date