Ronald Wygonik, D.D.S.

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www.killingworthdental.com

Patient Information

Patient's Name________________________ E-Mail address________________________

Home Phone____________ Work Phone____________ Birth Date____________ Marital Status____________

Parent's Name (if patient is under 18)________________________ Cell Phone________________________

Home Address________________________ City____________ State____________ Zip____________

Employer________________________ Occupation________________________

Person Responsible for Account____

Dental Insurance Carrier________________________ Policy Number________________________

Emergency Contact Name________________________ Phone________________________

Pharmacy________________________ Phone________________________

Preference for appointment reminders: Please Check One

- ☐ Phone Call
- ☐ E-Mail
- ☐ Text Message
- ☐ Postcard

Health Questionnaire

Name of Physician____

	Circle	
1. Are you under the care of a physician for a medical problem?	Yes	No
2. Have you been hospitalized in the past 5 years? If yes, please list on back.	Yes	No
3. Do you take any medications on a regular basis? If yes, please list on back.	Yes	No
4. Do you take an antidepressant medication? If yes, please list on back.	Yes	No
5. Are you subject to fainting, dizziness, nervous disorder, convulsions or headaches?	Yes	No
6. Do you have any breathing difficulty, such as asthma, emphysema, pneumonia, tuberculosis or any other lung disorder?	Yes	No
7. Do you have a heart murmur or mitral value prolapse or history of SBE?	Yes	No
8. Do you have prosthetic joints (i.e. knee or hip replacement)?	Yes	No

9. Do you have or have you had any of the following? (If Yes, please check)

______	Heart Disease	______	Anemia
______	Stroke	______	Epilepsy
______	Rheumatic Fever	______	Head/Neck Tumor
______	Hepatitis or Liver Disease	______	AIDS/HIV Positive
______	Arthritis	______	Radiation for a Malignancy
______	Kidney Disease	______	Sinus Problems
______	High Blood Pressure	______	Diabetes
______	Pacemaker	______	Other

10. Are you subject to prolonged bleeding?	Yes	No
11. Are you allergic to penicillin?	Yes	No
12. Are you allergic to Novocain?	Yes	No
13. Are you allergic to latex?	Yes	No
14. Please list any drug allergies________________________		
15. Are you pregnant?	Yes	No

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature____ Date____________