Whole family Dentistry℠
Restorative and Aesthetic Care

Welcome to our practice!

DR. TED C. KAWULOK AND ASSOCIATES

Name (first) _____ (middle initial) ____ (last) _____ (preferred name) _____

Address _____ City _____ State ____ Zip _____

Occupation _____ Social Security # _____ Birthdate _____

☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Divorced Phone(home) _____

Phone(cell) _____ Email _____ Auto Reminders ☐ Text ☐ Email ☐ None

Are you covered by dental insurance? ☐ Yes ☐ No

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS# /ID# _____ Employer Name _____

Insured's Address _____

Name of Insurance Company _____ Group Number _____

Mailing Address _____ Phone Number _____

How did you hear about us? ☐ Newspaper ☐ Web Search ☐ Phone Book ☐ Family ☐ Friend ☐ _____

Spouse's name _____

Dependent children's names and ages _____

Person to notify in an emergency _____ Relationship _____

Emergency phone numbers _____

I authorize the use of my radiographs and/or photographs for use in seminars and publications of Dr. Ted Kawulok.

X _____ Date _____

Signed (patient or parent/guardian if minor)

Briefly, state your desires in seeking dental health care _____

What is your primary concern that you would like us to address first? _____

When would you like us to start treatment ? Approximate date of your last dental visit? _____

Dental History

Are you delighted with your smile? _____ Please rate your smile from 1 to 10 (1= I hate my smile, 10 = awesome) _____

Do you now have any unhealed injuries, sores, or growths in or around your mouth? Y N

Do you experience regular headaches, or sore and tight muscles in the head and neck? Y N

Do your jaws pop, click, lock up, or do you experience difficulty opening your mouth? Y N

Please circle any of the following items if you have experienced them:

Braces	Chipped Teeth	Bleeding Gums	Reaction to a Local Anesthetic
Clenching	Periodontal Disease	Chronic Bad Breath	Treatment for Jaw Joint (TMJ)
Grinding	Gum Surgery	Tooth Sensitivity to hot/cold	Extracted Wisdom Teeth

Please list all medications you are currently taking:

Medication:	For what Condition:

Please list allergies to any drugs, food, or substances:

_____

_____

_____

Medical History

Height: _____ Weight: _____ Are you now, or have you been under a physician's care during the past five years? Y N

If so, when and for what purpose? _____

How would you rate your health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have any lung disorders? (Chronic Cough, pneumonia, emphysema, tuberculosis) Y N

Do you, or have you had a heart problem or heart surgery? Y N

Do you have, or have you had any of the following?

High Blood Pressure	Y	N	Epilepsy or Seizures	Y	N	Diabetes	Y	N
Mitral Valve Prolapse	Y	N	Asthma	Y	N	Immuno-suppression	Y	N
Prosthesis (joint, implant, valve)	Y	N	Glaucoma	Y	N	Bleeding Problems/Hemophilia	Y	N
Heart Murmur	Y	N	Kidney Disease or Dialysis	Y	N	Eating Disorder	Y	N
Pacemaker	Y	N	Thyroid Disease	Y	N	Rheumatic Heart Disease	Y	N
Tumor or Cancer	Y	N	Dialysis	Y	N	Rheumatic Fever	Y	N
Stroke or T.I.A.	Y	N	Arthritis	Y	N	Hepatitis or Liver Disease	Y	N
Ulcers	Y	N	HIV or AIDS	Y	N	Type? A B C Year Infected _____		

Do you smoke, vape or use smokeless tobacco? Y N If yes, which method and how often? _____

Is there anything else about your health that should be known? If so, what? _____

Medical Physician's Name: _____ Phone: _____

Physician's City and State: _____ Date of last physical exam: _____

Women are you (please circle):

Pregnant	Trying to become pregnant	Nursing
Experiencing Hormonal Imbalance	Taking Hormone Replacement	Taking Birth Control Pills

---

Signed: _____ Date: _____

The highest compliment our patients can give us is the referral of their friends and family. Thank you for your trust.