Dr. John C. Zabkowicz, D.D.S.
924 W. Oklahoma Avenue
Milwaukee, WI 53215

Patient Information (confidential)

Date _____

Home Phone ( ) _____

Name _____ Cell Phone ( ) _____

Soc. Sec. # _____ Birthdate _____ Email: _____

Address _____ City _____ State _____ Zip _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Patient/Parent's Employer _____ Work Phone ( ) _____

Business Address _____ City _____ State _____ Zip _____

Spouse/Parent _____ Employer _____ Phone ( ) _____

Whom may we thank for referring you? _____

Person to Contact In Case of Emergency _____ Phone ( ) _____

Responsible Party

Person Responsible for this Account _____ Relationship to Patient _____

Address _____ City _____ State _____ Phone ( ) _____

Birthdate _____

Employer _____ Work Phone ( ) _____ SSN# _____

Is this person currently a patient at our Dental Office? ☐ Yes ☐ No

Dental Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SSN# _____ Date Employed _____

Name of Employer _____ Union/Local# _____ Work Phone ( ) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Group # _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Do you have any additional insurance? ☐ yes ☐ no If yes, complete the following section:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SSN# _____ Date Employed _____

Name of Employer _____ Union/Local# _____ Work Phone ( ) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Group # _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State _____ Zip _____

I certify that I have read and understand all information to the best of my knowledge. All questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize & request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ Signature of patient (or parent if a minor)

Patient Medical History Patient Name _____

Physician _____ Office Phone# _____ Last Exam _____

1. Are you under medical treatment now? Y N
   If yes, explain _____
2. Have you been hospitalized for any surgical Operation or illness in the last 5 years? Y N
   If yes please explain- _____
3. Have you ever taken Phen-Fen/Redux Y N
4. Do you use tobacco? Y N
5. Do you use controlled substances? Y N
6. Are you wearing contact lenses? Y N
7. Are you allergic to or have you had any reactions to the following?

Local anesthetics	Y N
Penicillin or other Antibiotics	Y N
Sulfa drugs	Y N
Barbiturates	Y N
Sedatives	Y N
Iodine	Y N
Aspirin	Y N
Any metals (e.g. nickel, mercury, etc)	Y N
Latex rubber	Y N
Other _____	

8. Are you pregnant or think that you may be? Y N
   Are you nursing? Y N
   Are you taking an oral contraceptive? Y N

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

High Blood Pressure	Y	N	Heart Attack	Y	N	Rheumatic Fever	Y	N
Swollen Ankles	Y	N	Fainting/Seizures	Y	N	Asthma	Y	N
Low Blood Pressure	Y	N	Epilepsy/Convulsions	Y	N	Leukemia	Y	N
Diabetes	Y	N	Kidney Diseases	Y	N	AIDS or HIV	Y	N
Thyroid Problem	Y	N	Heart Disease	Y	N	Cardiac Pacemaker	Y	N
Heart Murmur	Y	N	Angina	Y	N	Frequently Tired	Y	N
Anemia	Y	N	Emphysema	Y	N	Cancer	Y	N
Arthritis	Y	N	Joint Replacement/Implant	Y	N	Hepatitis/Jaundice	Y	N
Sexually Trans. Disease	Y	N	Stomach Trouble/Ulcer	Y	N	Chest Pains	Y	N
Tuberculosis	Y	N	Radiation Therapy	Y	N	Glaucoma	Y	N
Recent Weight Loss	Y	N	Liver Disease	Y	N	Heart Trouble	Y	N
Respiratory Problems	Y	N	Mitral Valve Prolapse	Y	N	Stroke	Y	N
Hay Fever/Allergy	Y	N	Other _____					

Are you taking any medications including non-prescription medicine? Y N

If yes, what are they? _____

_____

_____

Patient Dental History

Name of Previous Dentist _____ Location _____ Last Exam _____

Do your gums bleed while brushing or flossing?	Y	N	Do you have frequent headaches?	Y	N
Are your teeth sensitive to hot and/or cold?	Y	N	Do you clench or grind your teeth?	Y	N
Are your teeth sensitive to sweet/sour foods/liquids?	Y	N	Do you bite your lips or cheeks frequently?	Y	N
Do you feel pain to any of your teeth?	Y	N	Have you had any difficult tooth extractions?	Y	N
Any sores/lumps in or near your mouth?	Y	N	Any prolonged bleeding after extractions?	Y	N
Have you had any head, neck, or jaw injuries?	Y	N	Have you had any orthodontic treatment?	Y	N
Have you had any of the following jaw problems?			Do you wear dentures or partials?	Y	N
Clicking	Y	N	If yes, date of placement _____		
Pain (joint, ear, side of face)	Y	N	Have you ever received oral hygiene instructions regarding		
Difficulty in opening or closing	Y	N	the care of your teeth and gums?	Y	N
Difficulty in chewing	Y	N	Do you like your smile?	Y	N

X _____ Signature of patient (or parent if a minor) Date _____

John C. Zabkowicz, D.D.S. 924 W. Oklahoma Ave. Mke, WI 53215

WISCONSIN CONSENT

(Wisconsin)

Purpose: This form is to obtain an individual's written permission under Wisconsin law for (a) our use of the individual's dental care records to carry out treatment, payment activities, and health care operations, and (b) our disclosure of the individual's dental care records to carry out treatment, payment activities, and health care operations.

SECTION A: Individual giving consent.

Name: _____

Patient Name: (If different than above) _____

Address: _____

Telephone: _____

TO THE INDIVIDUAL: Please read the following and complete the information requested.

Effect of Declining Consent: This consent is a condition of your treatment by us. If you decide not to sign this consent, we may decline to treat you.

Privacy Practices Notice: You have the right to read our Privacy Practices Notice before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our dental office's Notice of Privacy Practices accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

SECTION B: The uses and disclosures being authorized.

Our Use of Dental Health Information: By signing this form, you will consent to our use of your dental care records, to carry out treatment, payment activities, and health care operations as set forth in our Privacy Practices Notice.

Persons Involved in Care. By signing this form, you will consent to our use of your dental care records to the following persons, including those involved in your care or payment for that care. Please list the person(s) you would like involved in your care or payment for that care.

_____ _____

_____ _____

_____ _____

We may use professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person acting on your behalf to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of protected health information.

Our Disclosure of Medical Information. By signing this form, you will consent to our disclosure of your dental care records to carry out treatment, payment activities, and health care operations as set forth in our Privacy Practices Notice, and to our disclosure of your dental care records for disaster relief purposes as permitted by law

SECTION C: Revocation.

Right to Revoke: This consent is effective until revoked by you. You may revoke this consent at any time by giving written notice of revocation to the Contact Office listed below. Revocation of this consent will not affect any action we took in reliance on this authorization before we received your written notice of revocation. We may decline to treat you or to continue treating you if you revoke this consent.

Contact Office: John C. Zabkowicz, D.D.S

Telephone: 414-744-6777

Address: 924 W. Oklahoma Ave. Mke, WI 53215

INDIVIDUAL'S SIGNATURE.

I, _____, have had full opportunity to read and consider the contents of this consent. I understand that, by signing this form, I am confirming my written permission for the disclosure of my protected health information, as described in this form.

Signature: _____ Date: _____

If this consent is signed by a personal representative/parent on behalf of the individual, complete the following:

Personal Representative's/Parent Name: _____

Relationship to Individual: _____

NEXT PAGE →

John C. Zabkowicz, D.D.S. 924 W. Oklahoma Ave. Mke, WI 53215

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____