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

NEW ALBANY, OHIO 43054
TELEPHONE (614) 855-0202

Today's Date:______________________
Name:______________________
I like to be called/ Nickname:______________________
Home Address:______________________
____
Home Phone:______________________
Cell Phone:______________________
E-mail Address:______________________
Birthday:______________ ☐ Male ☐ Female
Social Security #:______________________
☐ Single ☐ Married ☐ Widowed ☐ Divorced
How did you find our office?______________________
If Referred, by whom?______________________
Our office is now confirming appointments via e-mail and text.
Which of these methods would you prefer to be contacted by?
☐ E-mail ☐ Text ☐ Both

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? ☐ Y ☐ N
Are you currently in pain? ☐ Y ☐ N
Do you think you have cavities? ☐ Y ☐ N
Do your gums ever bleed? ☐ Y ☐ N
Do you think you have gum disease? ☐ Y ☐ N
Do you feel that you have bad breath? ☐ Y ☐ N
Does your jaw ever ache? ☐ Y ☐ N
Does you jaw ever "pop" or "lock" position? ☐ Y ☐ N
Do you grind your teeth at night or during the day? ☐ Y ☐ N
Do you experience several headaches per week? ☐ Y ☐ N
Are you interested in cosmetic dentistry/bleaching? ☐ Y ☐ N
Your current dental health is: ☐ Good ☐ Fair ☐ Poor

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

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? ☐ Y ☐ N
If yes, please list:______________________
____
____

Do you have a personal Physician? ☐ Y ☐ N
Name:______________________
Phone #:______________________
Approximate last visit:______________________
Your current PHYSICAL health is?
☐ Good ☐ Fair ☐ Poor
Have you ever had any serious medical problems in the past 5 years? ☐ Y ☐ N
If yes, please explain?______________________
____
Do you smoke? ☐ Y ☐ N
Do you chew tobacco? ☐ Y ☐ N
For Women: Are you pregnant? ☐ Y ☐ N

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:______________________

Medical History

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

Y N Heart Attack
Y N Stroke
Y N Heart Murmur
Y N Rheumatic Fever
Y N Heart Surgery/
Type:______________
Y N Pacemaker
Y N Artificial Heart Valve
Y N Mitral Valve Prolapse
Y N Anemia
Y N Hepatitis/
Type:______________
Y N High Blood Pressure
Y N Low Blood Pressure
Y N Epilepsy
Y N Seizures
Y N Fainting Spells
Y N Hemophilia/ Bleeding Disorder
Y N Joint Replacement/
Type:______________
Y N Brain Aneurism
Y N Cancer/
Type:______________
When:______________
Y N Radiation Treatment/
When:______________
How Many:__________
Y N Chemotherapy/
When:______________
How Many:__________
Y N HIV & AIDS
Y N Asthma
Y N Tuberculosis (TB)
Y N Sickle Cell Disease
Y N Psychiatric Problems
Y N Kidney Problems
Y N Liver Problems
Y N Diabetes
Y N Bowel Problems
Y N Back Pain
Y N Neck Pain
Y N Severe Headaches
Y N Sinus Problems
Y N Fever Blisters

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Y N Sinus Problems
Y N Fever Blisters

Have you ever experienced any disease or medical problem that is not listed above? Y N
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? Y N

Signature:____________________ Signature:____________________ Signature:____________________
Date:_________________________ Date:_________________________ Date:_________________________