

Personal Information-Health History

Dr. Vicki Borowski, D.D.S.

17300 Preston Road, Suite 100, Dallas, TX 75252

Phone: 972-380-6223 Fax: 972-248-6560

Email: info@vickiborowski.com web: www.vickiborowski.com

NAME _____ Birthday: _____ Social Security # _____

Mailing Address _____ City, State and Zip Code _____

HOW OR WHO REFERRED YOU TO OUR OFFICE? _____

PHONES: Work: _____ Home: _____ FAX: _____

Cell: _____ Pager: _____ **EMAIL:** _____

OCCUPATION: _____ **EMPLOYER & address** _____

Dental Insurance: Name of Ins. Company: _____ Telephone Number : _____

Are you the primary policy holder Yes No If No please enter policy holders information below

Spouse's **Name** _____ **EMPLOYER & address** _____

ACCOUNT RESPONSIBILITY if someone other than yourself: Name: _____

Their Social Security No.: _____ Birthday : _____

Mailing Address: _____ Daytime Phone _____

Notice of Privacy Practices: The privacy of your health information is important to us. During your initial visit, please review the notice of privacy practices regarding uses and disclosures of your health information.

INSURANCE POLICY: If you have dental insurance, we will send the claim electronically for you, and have the reimbursement sent directly to Dr. Borowski. We will estimate your portion and ask that you take care of it at the time of service. Any balance remaining after insurance pays is the responsibility of the patient.

HEALTH HISTORY (please check if you have or had any of the following:)

<input type="checkbox"/> Yes <input type="checkbox"/> No Are you in good health?	<input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes
<input type="checkbox"/> Yes <input type="checkbox"/> No Has your health changed in the last year	<input type="checkbox"/> Yes <input type="checkbox"/> No Tumors, cancer
<input type="checkbox"/> Yes <input type="checkbox"/> No Chest pain, shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No Radiation treatment
<input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding problems, bruise easily	<input type="checkbox"/> Yes <input type="checkbox"/> No Psychiatric care
<input type="checkbox"/> Yes <input type="checkbox"/> No Headaches, ringing in ears	<input type="checkbox"/> Yes <input type="checkbox"/> No Kidney or bladder disease
<input type="checkbox"/> Yes <input type="checkbox"/> No Joint pain or stiffness, arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No VD, herpes
<input type="checkbox"/> Yes <input type="checkbox"/> No Fainting or seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No HIV positive, AIDS, ARC
<input type="checkbox"/> Yes <input type="checkbox"/> No Heart disease, murmurs, rheumatic fever, prosthetic heart valve	<input type="checkbox"/> Yes <input type="checkbox"/> No Pregnant: month _____
<input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No Birth control Pills
<input type="checkbox"/> Yes <input type="checkbox"/> No High Blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No Recreational drugs smoking/ alcohol
<input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis or liver disease	
<input type="checkbox"/> Yes <input type="checkbox"/> No TB, emphysema or lung disease	

List any and all **ALLERGIES:** _____

List any and all **DRUGS/MEDICATIONS** you are taking: _____

List any and all **SURGERIES:** _____

Yes No Are you being treated by a Doctor now? Who? _____

The above information is true and correct to the best of my knowledge:

PATIENT SIGNATURE: _____ DATE: _____