Richard D. Kubicek, D.D.S., P.C
920 2nd Street--Friend, NE 68359

Patient Name:_____ Date:_____
Spouse's Name:_____ Patient Date of Birth:_____
Home Address:_____ Home Phone:_____
City:_____ State:_____ Zip:_____ Cell Phone:_____
Place of Employment:_____ Work Phone:_____
_____ Social Security Number:_____

Person to contact in case of emergency:_____ Phone:_____
Physician:_____ Office Phone:_____

PATIENT MEDICAL HISTORY

	Yes	No
Are you under medical treatment now?	☐	☐
Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
Are you taking any medication(s) including non-prescription medicines?	☐	☐

If yes, list the medication(s) are you taking?

_____

_____

Are you allergic to or have you had any reactions to the following?

	Yes	No		Yes	No
Local anesthetics? (eg. Novocaine)	☐	☐	Barbiturates	☐	☐
Sulfa	☐	☐	Sedatives	☐	☐
Penicillin	☐	☐	Antibiotics_____	☐	☐
Aspirin	☐	☐	Codeine	☐	☐
Latex	☐	☐	Acrylic	☐	☐
Metal	☐	☐	Other_____	☐	☐

List any health problems or diseases that you have._____

Yes No
☐ ☐ **Have you ever taken Fosamax, Actonel, Boniva, Zometa, Reclast, Aredia, Didronel or any bisphosponate medications.**

	Yes	No
Do use tobacco?	☐	☐
Do you use alcohol?	☐	☐
Do you use cocaine?	☐	☐
Do you use other drugs?	☐	☐

WOMEN ONLY:

	Yes	No
Are you pregnant or think you may be pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking birth control pills?	☐	☐

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

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Epilepsy/Convulsions	☐	☐	Chest Pains	☐	☐
Joint Replacement or Implant	☐	☐	Liver Disease	☐	☐	Easily Winded	☐	☐
Previous Joint Infection	☐	☐	Hepatitis/Jaundice	☐	☐	Respiratory Problems	☐	☐
Heart Valve Replacement	☐	☐	Steroid Medication	☐	☐	Emphysema	☐	☐
Heart Valve Repair	☐	☐	AIDS or HIV Infection	☐	☐	Tuberculosis	☐	☐
Spleen removed	☐	☐	Thyroid Problem	☐	☐	Anemia	☐	☐
Dialysis	☐	☐	Blood Transfusion	☐	☐	Asthma	☐	☐
Port or PICC line	☐	☐	Alzheimer's Disease/Dementia	☐	☐	Hay Fever/Allergies	☐	☐
Bleeding Problems/Hemophilia	☐	☐	Heart Trouble	☐	☐	Frequently Tired	☐	☐
Systemic Lupus	☐	☐	Angina	☐	☐	Sexually Transmitted Disease	☐	☐
Cancer	☐	☐	Stroke	☐	☐	Stomach Troubles/Ulcers	☐	☐
Chemotherapy	☐	☐	Heart Attack	☐	☐	Alcohol Dependency	☐	☐
Radiation Therapy	☐	☐	Kidney Disease	☐	☐	Drug Dependency	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Glaucoma	☐	☐
Multiple Myeloma	☐	☐	Low Blood Pressure	☐	☐	Recent Weight Loss	☐	☐
Diabetes (Type I or Type II)	☐	☐	Fainting/Seizures	☐	☐	Swollen Ankles	☐	☐
Osteoporosis	☐	☐	Cardiac Pacemaker	☐	☐	Other_____		

Chief Dental Concern_____

I certify that I have read and understand the above information, to the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

**I understand all accounts more than 30 days past due will be charged interest at 1.5% per month.

Signature:_____ Date:_____
Patient, Parent or Guardian