



MEDICAL HISTORY

Physician's name _____ Phone _____

Date of last visit _____ Purpose of last visit _____

Women: Pregnant? Yes No Birth Control pills? Yes No Osteoporosis medication? Yes No

List all current medications: _____

List all allergies - medications, environmental, etc. _____

Check Yes or No whether you have had any of the following:

- | | | |
|-----------------------------|-------------------------|-----------------------------|
| Y N AIDS/HIV Positive | Y N Fainting | Y N Mitral valve prolapse |
| Y N Anaphylaxis | Y N Glaucoma | Y N Pacemaker |
| Y N Anemia | Y N Headaches | Y N Psychiatric care |
| Y N Arthritis | Y N Heart murmur | Y N Radiation treatment |
| Y N Artificial heart valves | Y N Heart problems | Y N Respiratory disease |
| Y N Artificial joints | Y N Hemophilia | Y N Rheumatic/Scarlet fever |
| Y N Asthma | Y N Herpes | Y N Shingles |
| Y N Back problems | Y N Hepatitis | Y N Shortness of breath |
| Y N Cancer | Y N High Blood Pressure | Y N Stroke |
| Y N Chemical dependency | Y N Jaw Pain | Y N Thyroid disease |
| Y N Chemotherapy | Y N Kidney disease | Y N Tobacco habit |
| Y N Diabetes | Y N Latex allergy | Y N Tuberculosis |
| Y N Epilepsy | Y N Liver disease | Y N Ulcer/colitis |

Additional notes: _____



JOHN M. KOROLEWSKI, D.D.S.

I have completed these questions to the best of my knowledge and understand that this information will be used by Dr. Korolewski to determine appropriate and safe dental care. I will inform this office of any change in my medical status.

I authorize any insurance company to pay to Dr. Korolewski all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I understand that I am responsible for all fees for services rendered whether or not paid for by insurance.

I authorize the diagnosis of my dental health by means of radiographs, study models, digital photographs and any other diagnostic aids deemed appropriate. I also authorize the release of any diagnostic or treatment information to third-party insurance carriers/payors or healthcare practitioners.

Signature of Patient, Parent or Guardian:

Signature: _____

Date: _____

HEALTHY SMILES • GENTLE, PERSONALIZED CARE

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