WEST KALAMAZOO DENTAL CARE

PATIENT INFORMATION

Today's Date: _____

Patient Name: _____
Last First Middle Preferred

Birth Date: _____ Gender: _____ Employer: _____

Address: _____
Street City State Zip

Phone: _____
Home Work Cell Email

Primary Care Physician (Name/Phone/Fax): _____

Whom may we thank for referring you to our office: _____

Responsible Parent/Guardian Name: _____
Last First Middle

Birth Date: _____ Gender: _____ Occupation/Employer: _____

Address: _____
Street City State Zip

Phone: _____
Home Work Cell Preferred

Primary Dental Insurance Information:

Subscriber's Name: _____ Subscriber's Birth Date: _____

Insurance Co.: _____ Subscriber's ID: _____ Group No.: _____

Employer: _____ Subscriber's Relation to Patient: _____

Secondary Dental Insurance Information:

Subscriber's Name: _____ Subscriber's Birth Date: _____

Insurance Co.: _____ Subscriber's ID: _____ Group No.: _____

Employer: _____ Subscriber's Relation to Patient: _____

DENTAL HISTORY

Last dental EXAM/TREATMENT, Date: _____			Are your teeth SENSITIVE to hot, cold, sweets, pressure?	Yes	No
Do you have any dental/oral PAIN? Where? _____	Yes	No	Are you aware if you GRIND or CLENCH of your teeth?	Yes	No
Do you wear DENTURES/PARTIALS?	Yes	No	Do you have HEADACHES, ear aches, or neck pain?	Yes	No
If yes, how LONG have you had your DENTURES/PARTIALS?	___		Are you unhappy with the APPEARANCE of your teeth?	Yes	No
Are you NERVOUS/APPREHESIVE about dental treatment?	Yes	No	Do you have DISCOLORED teeth which bother you?	Yes	No
Have you had a BAD dental experience in the past?	Yes	No	Would you like your SMILE to look better or different?	Yes	No
Have you had any PERIODONTAL (GUM) treatments?	Yes	No	Do you use dental FLOSS regularly?	Yes	No
Do your gums BLEED or feel TENDER?	Yes	No			

Consent for Dental Treatment:

I give consent for dental treatment, for the patient named above, to be provided by the dentists and staff at West Kalamazoo Dental Care. This treatment may include, but is not limited to; dental fillings, dental extractions, root canals, dental cleanings, periodontal therapy, and administration of drugs common to dental practice such as local anesthetics and nitrous oxide. I understand there are risks inherent to all dental procedures. I also understand I am free to ask any questions regarding my proposed treatment options and the risks involved with those procedures. I also understand that pursuant to the Michigan Public Health Code, an HIV/AIDS test may need to be performed after such time any employee at West Kalamazoo Dental Care sustains a percutaneous, mucous membrane, or open wound exposure to my blood or other body fluids.

☑ Signature of Patient, Parent or Guardian: _____ Date: _____

Over Please →

WEST KALAMAZOO DENTAL CARE

MEDICAL HISTORY

Today's Date: _____

Patient Name: _____ Birth Date: _____

I. PLEASE CIRCLE APPROPRIATE ANSWER FOR EACH:

DO YOU HAVE OR HAVE YOU HAD:

Yes	No	Heart Disease	Yes	No	Difficulty swallowing	Yes	No	Arthritis/Rheumatism
Yes	No	Heart Attack	Yes	No	Diarrhea/Constipation	Yes	No	Artificial Joint/ Replacement
Yes	No	High Blood Pressure	Yes	No	Vomiting/Nausea	Yes	No	AIDS/HIV
Yes	No	Chest Pain (Angina)	Yes	No	Bloody Stool/Urine	Yes	No	Herpes Simplex
Yes	No	Congenital Heart Defect/disease	Yes	No	Stomach Problems/Ulcers	Yes	No	Skin Disease
Yes	No	Infection of the Heart or Blood	Yes	No	Thyroid/Adrenal Dysfunction	Yes	No	Eye Disease
Yes	No	Prosthetic Heart Valve	Yes	No	Headaches/Dizziness	Yes	No	Cancer
Yes	No	Pacemaker/Implanted Device	Yes	No	Fainting	Yes	No	Radiation Treatments
Yes	No	Stroke	Yes	No	Seizures	Yes	No	Chemotherapy
Yes	No	Bleeding Problems	Yes	No	Increase Thirst/Urination	Yes	No	Blood Transfusion
Yes	No	Blood disease/disorders	Yes	No	Diabetes	Yes	No	Psychiatric care
Yes	No	Anemia	Yes	No	Kidney Disease	Yes	No	Tobacco (any form)
Yes	No	Sinus Problems	Yes	No	Hepatitis/Liver Disease	Yes	No	Alcoholism
Yes	No	Asthma	Yes	No	Dry Mouth	Yes	No	Recreational Drugs
Yes	No	TB (Tuberculosis)	Yes	No	Joint Pain/Stiffness	Yes	No	Are you Pregnant/ Nursing
Yes	No	COPD/Emphysema	Yes	No	Osteoporosis	Yes	No	Taking Birth Control
						Yes	No	Diagnosis Sleep Apnea

PLEASE LIST ANY OTHER DISEASES/MEDICAL CONCERNS: _____

II. ARE YOU ALLERGIC TO OR HAVE YOU REACTED TO ANY OF THE FOLLOWING?

Penicillin Codeine Aspirin Nitrous Oxide Local Anesthetic Latex Motrin/Ibuprofen

PLEASE LIST ALL OTHER ALLERGIES: _____

III. PLEASE PROVIDE A LIST OF ALL MEDICATIONS YOU ARE TAKING AND WHAT THEY ARE FOR:

_____

_____

_____

IV. PLEASE LIST ALL HOSPITALIZATIONS/SURGERIES/PROCEDURES IN THE PAST 10 YEARS:

_____

To the best of my knowledge, I have answered all questions completely and accurately. I will inform my dentist of any changes in my health and/or medications at each visit.

☑ Patient Signature: _____ Date: _____

(Office Only)

Reviewed by Doctor:
Doctor Signature: _____ Date: _____

Updates by Doctor:
Initial & Date: _____ _____ _____