WYANDOTTE FAMILY DENTAL

2244 FORD AVENUE, WYANDOTTE, MICHIGAN 48192

Name: _____ Preferred Name: _____

Title: Mr. Mrs. Ms. Dr. Child Male / Female Marital Status _____

Address: _____

City: _____ State: _____ Zip: _____

Who is the responsible party for this patient? _____

Social Security #: _____

Driver's License #: _____

Date of Birth: _____

Email: _____

Primary Contact Phone #: _____

Secondary Contact Phone #: _____

Emergency Contact Name: _____ Phone # _____

How did you find our office? _____

MEDICAL HISTORY Check if you have a history of the following

____ Heart Problems	____ Arthritis	____ Hepatitis
____ Artificial Joints	____ Steroid Medications	____ Stroke
____ High Blood Pressure	____Osteoporosis Meds	____ Seizures
____ Cancer	____ Chemical Dependency	____ Epilepsy
____ Chemotherapy	____ AIDS	____ Tuberculosis
____ Radiation Therapy	____ General Allergies	____ Diabetes
____ Immunodeficiency's	____ Latex Allergies	____ Asthma

____ Drug Allergies, if yes, please list _____

Physician's Name: _____ Phone #: _____

What other conditions do you have? _____

What Medications are you taking, (including aspirin and herbal supplements):_____
_____

Do you smoke? _____ Have you traveled outside the USA in the last two months? _____

DENTAL INFORMATION

Approximate Date of Last Dental Visit: _____

Chief Complaint: _____

Are your teeth sensitive? _____ **What are your teeth sensitive to?** _____

Jaw Problems: Does your jaw click? _____ Does your jaw hurt? _____

Do you get headaches? ____ What type of headaches?_____

What Sports do you participate in? _____

I, _____ allow use of my picture and/or testimonial on the website or other media.

DENTAL INSURANCE INFORMATION

Employer: _____

Primary Insurance Name: _____ Phone # _____

Insured's Name: _____ Relation to Patient _____

Insured's ID # _____ Insured's Date of Birth _____

Insured's Employer _____Employer Phone # _____

Work Address: _____

Group # _____ Effective Date: _____

Secondary Insurance Name: _____ Phone # _____

Insured's Name: _____ Relation to Patient _____

Insured's ID # _____ Insured's Date of Birth _____

Insured's Employer _____Employer Phone # _____

Work Address: _____

Group # _____ Effective Date: _____

The information that I have given is correct to the best of my knowledge. I authorize my insurance to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature: _____ Date: _____