Wyandotte Family Dental

2244 Ford Ave Wyandotte, MI 48192

Name: _____ **Preferred Name:** _____

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

Address: _____

City: _____ State: _____ Zip: _____

Social Security #: _____ Driver's License #: _____

Date of Birth: _____

Email Address: _____

Primary Phone #: _____Home/Cell

Secondary Phone #: _____Home/Cell

How do you prefer reminders? Text, Email or Both

Who is responsible for this patient? _____

Emergency Contact Name:_____ Phone #:_____

How did you find our office? _____

Medical History Check if you have a history of the following

____ AIDS/HIV ____ Artifical Joints ____ Arthritis ____ Asthma

____ Cancer ____ Chemotherapy ____ Radiation ____ Diabetes

____ Epilepsy / Seizures ____ General Allergies ____ Latex Allergy ____ Hepatitis

____ Herpes / Cold Sores ____ Immunodeficiency ____ Mental Disorders ____ Tuberculosis

____ Osteoporosis Meds ____ Thyroid Disease ____High Blood Presure ____ Stroke

____ Steroid Medication

____ Chemical Dependency ____Smoke Cigarettes / Marijuana ____ Chew Tobacco ____ Vape

Heart Problems: _____Pacemaker / Defibrillator ____ Artifical Valves

Drug Allergies: _____

Physician's Name: _____ Phone # _____

What other conditions do you have? _____

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

_____

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: _____