WyandotteFamily Dental

2244 Ford Ave. Wyandotte, MI 48192

Name:_____ Preferred Name_____

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

Address:_____

City:_____ State:_____ Zip Code:_____

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 hear about our office?_____

Medical History Check if you have a history of the following:

____ AIDS/HIV	_____Artificial Joints	____Arthritis	____Asthma
____ Cancer	____Chemotherapy	____Radiation	____Diabetes
____ Epilepsy/Seizures	____General Allergies	____Latex Allergy	____Hepatitis
____ Herpes/ Cold Sores	____Immunodeficiency	____Mental Illness	____Tuberculosis
____ Osteoporosis Meds	____Thyroid Disease	____High Blood Pressur	____Stroke
____ Steroid Medications	____Developmental Disability		

_____ Substance use disorder

Heart Problems:_____ Pace Maker / Defibrillator ____Artificial 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.

DENTAL INSURANCE INFORMATION

Employer: _____

Primary Insurance Name: _____ Phone # _____

Insured Name: _____ Relation to patient:_____

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

Insured's Employer: _____ Employer's Phone # _____

Work Address:_____

Group # _____ Effective Date :_____

Secondary Insurance Name: _____ Phone #_____

Insured Name: _____ Relation to patient:_____

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

Insured's Employer: _____ Employer's 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 benefits. I understand that I am financially responsible for all charges whether or not paid by insurance

Signature:_____ Date: _____