**VanDeVelde and Matheson, DDS PC**
124 N. Hanselman St. • Bad Axe, MI 48413
(989) 269-8401

**Caro Family DENTISTRY**
206 Montague Ave. • Caro, MI 48723
(989) 672-5022

**Marlette Family DENTISTRY**
3149 Main St., Suite 6 • Marlette, MI 48435
(989) 635-7541

## Your Child . . .

Child's Name _____

Nickname _____ Sex _____

Birthday _____ Age _____

SS# _____

School _____ Grade _____

Child's Home Address _____

City _____ State _____ Zip _____

Phone _____

## Responsible Party . . .

Name _____

Relationship _____

Address _____

City _____ State _____ Zip _____

Email _____

Phone _____ Work Phone _____

SS# _____

DL# _____

## ☐ Mother ☐ Stepmother ☐ Guardian

Name _____

Cell Phone _____

Work Phone _____ Ext. _____

Email _____

Employer _____

Occupation _____

SS# _____ D.O.B. _____

DL # _____

***Marital Status*** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner

## ☐ Father ☐ Stepfather ☐ Guardian

Name _____

Cell Phone _____

ork P

Email _____

Employer _____

Occupation _____

S#__

DL # _____

***Marital Status*** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner

## Primary Dental Insurance

Insurance Company _____

Insured's Name _____

Relationship _____

Birthdate _____ SS# _____

Employer _____

Occupation _____

## Secondary Dental Insurance

Insurance Company _____

Insured's Name _____

Relationship _____

Birthdate _____ SS# _____

Employer _____

Occupation _____

## Additional Dental Insurance

Insurance Company _____

## Additional Dental Insurance

Insurance Company _____

# Medical History

What is your impression of your present health? _____ Year last medical physical? _____

(1) **Please draw a circle around any of the following which you have had or have at present:**

| | | | | |
|---|---|---|---|---|
| Heart Disease or Condition | Rheumatic Fever | Asthma | Hepatitis | Joint Replacement |
| Angina Pectoris | Stroke | Hay Fever | Thyroid Disease | Venereal Disease (Syphilis, Gonorrhea) |
| Frequent Chest Pains | Hemophilia | Emphysema | Glaucoma | Drug Addiction |
| High Blood Pressure | Bruise Easily | Tuberculosis (TB) | Epilepsy or Seizures | Psychiatric Treatment |
| Shortness of Breath | Prolonged or Unusual Bleeding | Diabetes | Fainting or Dizzy Spells | Cancer |
| Swollen Ankles | Anemia | Ulcers | AIDS or AIDS Related Complex | Radiation Therapy |
| Artificial Heart Valve | Blood Transfusion | Kidney Trouble | HIV Positive | Chemotherapy |
| Congenital Heart Disease | Sickle Cell Disease | Liver Disease | Cold Sores | Implant Prosthesis |
| Heart Murmur | Arthritis | Jaundice (Other than at birth) | Genital Herpes | Unexplained Weight Loss |

**Check YES or NO for the following questions.** (*If in doubt, check YES.* If YES, please give details.)

| | | | |
|---|---|---|---|
| (2) | Are you presently, or have you been under the care of a physician during the past year? Physician's name: | ☐ YES | ☐ NO |
| (3) | Are you presently taking any medicine or drugs? | ☐ YES | ☐ NO |
| (4) | Are you sensitive/allergic to latex? | ☐ YES | ☐ NO |
| (5) | Are you allergic to any medicine or materials? | ☐ YES | ☐ NO |
| (6) | Circle or list if you have ever taken: Alendronate (Fosamax) Ibandronate (Boniva) Risedronate (Actonel) Pamidronate (Aredia) Zoledronate (Zometa) or any other drugs to treat osteoporosis: | ☐ YES | ☐ NO |
| (7) | Have you ever had a reaction to a local anesthetic? | ☐ YES | ☐ NO |
| (8) | Have you ever experienced any complication or illness following dental treatment? | ☐ YES | ☐ NO |
| (9) | Do you have any diseases or conditions not listed above? | ☐ YES | ☐ NO |
| (10) | Have you ever been told you were not eligible to be a blood donor? | ☐ YES | ☐ NO |
| (11) | Do you use tobacco? *(If YES, please circle and give frequency.)* SMOKE: Cigarettes Cigars Pipe SMOKELESS: Chewing Tobacco Snuff or "Dip" FREQUENCY: _____ | ☐ YES | ☐ NO |
| (12) | WOMAN: Are you pregnant? *(If YES, please check trimester block)* | ☐ YES ☐ NO | ☐ 1 ☐ 2 ☐ 3 |

I understand by bringing in my child for dental treatment, I am responsible for the treatment payment independent of what a divorce decree may state. Payment/ Reimbursement must be made between the divorced parents. VanDeVelde & Matheson will not intervene. Payment due day of service. _____ *(Initial)*

I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform the office of any personal, medical or insurance changes.

Signature _____ Date _____
(REQUIRED)

Please list any additional people whom we may share the patient's treatment, scheduling, and financial information with. Due to the Standards for Privacy of Individually Identifiable Health Information ("Privacy Rule"), any person not specifically named on this form will NOT be able to obtain any information.

**NAME:** **RELATIONSHIP TO PATIENT:**

_____ _____

_____ _____

| BLOOD PRESSURE | DATE | BLOOD PRESSURE | DATE | BLOOD PRESSURE | DATE | BLOOD PRESSURE | DATE |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

| DENTIST'S SIGNATURE | DATE | REVIEWER | DATE | REVIEWER | DATE | REVIEWER | DATE |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

CLEMCO PRINTING – BAD AXE; 7-30-19M2