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

# 1.) About You . . .

Today's Date: _____ I prefer to be called: _____ ☐ Male ☐ Female

**Name:** _____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Last First MI Mr Mrs Ms Dr

E-mail Address: _____ Birthdate: ___ / ___ / ___ Age: _____ SS #: _____

**Home Address:** _____
Street City State Zip

Home Ph: (___) _____ Pager/Cell: (___) _____ Work Ph: (___) _____ Drivers License #: _____

Where and when are best times to reach you? _____ Who may we **thank** for referring you? _____

Other family members seen by us: _____

Previous/Present Dentist: _____ Last Visit Date: _____
(Please Circle)

**Employer:** _____ How long there? _____ Occupation: _____

Employer's Address: _____
Street/PO Box City State Zip

# 2.) Dental Insurance . . .

## PRIMARY INSURANCE

Medical Coverage? ☐ Yes ☐ No Dental Coverage? ☐ Yes ☐ No Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____ Phone #: ( ___ ) _____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's SS #: _____ Insured's Birthdate: ___ / ___ / ___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

## SECONDARY INSURANCE

Medical Coverage? ☐ Yes ☐ No Dental Coverage? ☐ Yes ☐ No Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____ Phone #: ( ___ ) _____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's SS #: _____ Insured's Birthdate: ___ / ___ / ___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

# 3.) Spouse Information . . .

His/Her Name: _____ Birthdate: ___ / ___ / ___ SS #: _____

Employer: _____ Work Ph: (___) _____ Ext: _____ Drivers License #: _____

# 3.) Spouse Information - continued . . .

**Employer:** _____ How long there? _____ Occupation: _____

Employer's Address: _____
Street/PO Box City State Zip

# 4.) 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 |

| PATIENT COMMENTS | SIGNATURE OF PATIENT *(or legal guardian if patient is a minor)* | DATE |
|---|---|---|
| | X | X |

DENTIST'S COMMENTS

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

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

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