Welcome

ADA Family Dentistry, P.L.C.

Kurt E. Schabes, D.D.S. , P.L.C.

(616) 676-2223

About You

Today's date: ________________ Email Address ________________________________

Name: ____
Last First Mi Mr Mrs Ms Dr

I Prefer To Be Called: ________________________________ ❑ Male ❑ Female

Birthdate: _____/_____/_____ Age: ________ Social Security #: ________________

Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home Address: ____
Street City State Zip

Home Phone #: (_______)________________________ Cell #: (_______)________________

Work Phone #: (_______)________________Ext.________Driver's License #: ____________

Where & when are the best times to reach you?_______________________________

Whom may we thank for referring you? ______________________________________

Other family members seen by us: ____

Employer: ______________________ How long there? ________ Occupation ____________

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

Neighbor or Relative not living with you

His / Her Name: ____________ Relation: ________ Work Phone #: (____) ____________ Home Phone #: (____) ____________

Address: ____
Street City State Zip

Spouse Information

His / Her Name:________________________ Birthdate: _____/____/_____ Social Security #: ____________

Employer: ________________ Work Phone #: (_____) __________ Ext: ______Driver's License #: ____________

Insurance Information

Primary Insurance Dental Coverage? ❑ Yes ❑ No Medical 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 Social Security #: __________ Insured's Birthdate: ____/____/____ Relation: ________

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

Secondary Insurance Dental Coverage? ❑ Yes ❑ No Medical 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 Social Security #: __________ Insured's Birthdate: ____/____/____ Relation: ________

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

Dental History

Why have you come to the dentist today? ______________________

____

Are you currently in pain? ❑ Yes ❑ No

Do you need to be premedicated before dental treatment? ❑ Yes ❑ No

Your current dental health is ❑ Good ❑ Fair ❑ Poor

Do you floss daily ❑ Yes ❑ No Brush daily? ❑ Yes ❑ No

Type of bristles on your toothbrush? ❑ Hard ❑ Medium ❑ Soft

Do your gums ever bleed? ❑ Yes ❑ No Ever Itch? ❑ Yes ❑ No

Have you ever had periodontal disease? ❑ Yes ❑ No

Are your teeth sensitive to heat, cold, or anything else? ______________

Do you have mobility in your teeth? ❑ Yes ❑ No

Do you still have wisdom teeth? ❑ Yes ❑ No

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

Are you happy with the appearance of your teeth? ❑ Yes ❑ No

Have you ever had Orthodontic treatment? ❑ Yes ❑ No

Orthodontist name: ______________________

Do you have dentures/partials or any appliances? ❑ Yes ❑ No

Does your jaw click? ❑ Yes ❑ No

Do you have difficulty opening your mouth widely? ❑ Yes ❑ No

Last date teeth were cleaned: ______________

Were x-rays taken? ❑ Yes ❑ No

Favorite brand of toothpaste: ______________

Would you like whiter teeth? ❑ Yes ❑ No

Preferences: Local anesthetic only ❑ Local & gas sedation ❑

Gas sedation only ❑ No anesthetic ❑

Medical History

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name ______________________

Address ______________________
Street

____
City State Zip

Phone # (_____) ______________ Date of last visit __________

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain: ______________________

Do you smoke or use tobacco in any other form? ❑ Yes ❑ No

For Women: Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Unsure ❑ Yes ❑ No

Week # ________ Are you nursing? ❑ Yes ❑ No

Do you or have you experienced the following?

❑ Abnormal Bleeding
❑ Alcohol Abuse
❑ Anemia
❑ Arthritis
❑ Artificial Bones/Joints
❑ Artificial Valves
❑ Asthma
❑ Blood Transfusion
❑ Cancer
❑ Chemotherapy
❑ Chicken Pox
❑ Colitis
❑ Congenital Heart Defect
❑ Diabetes
❑ Difficulty Breathing
❑ Drug Abuse
❑ Emphysema
❑ Epilepsy
❑ Fainting Spells
❑ Fever Blisters
❑ Glaucoma
❑ Hay Fever
❑ Headaches
❑ Heart Attack
❑ Heart Murmur
❑ Heart Surgery
❑ Hemophilia
❑ Hepatitis
❑ Herpes
❑ High Blood Pressure
❑ HIV+/AIDS
❑ Hospitalized for Any Reason
❑ Kidney Problems
❑ Liver Disease
❑ Low Blood Pressure
❑ Lupus
❑ Mitral Valve Prolapse
❑ Pacemaker
❑ Persistent Cough
❑ Psychiatric Problems
❑ Radiation Treatment
❑ Rheumatic Fever
❑ Scarlet Fever
❑ Seizures
❑ Shingles
❑ Sickle Cell Disease
❑ Sinus Problems
❑ Steroid Therapy
❑ Stroke
❑ Thyroid Problems
❑ Tonsillitis
❑ Tuberculosis (TB)
❑ Ulcers
❑ Use of Inhaler
❑ Venereal Disease

Please list any serious medical condition(s) that you have experienced: ______________________

Are you taking any prescription/over-the-counter drugs? ❑ Yes ❑ No If yes, please list each one ______________________

____

Are you/have you taken bisphosphonates? ❑ Yes ❑ No If yes, please list each one: ______________________

Are you allergic to any of the following?

❑ Aspirin
❑ Barbiturates
❑ Codeine
❑ Dental Anesthetics
❑ Erythromycin
❑ Jewelry / Metals
❑ Latex
❑ Penicillin
❑ Sedatives
❑ Sulfa Drugs
❑ Tetracycline
❑ Other

Please list anything additional that causes allergic reactions: ______________________

____

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need including photographs needed for diagnostic and/or educational purposes. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover.

____
Signature Date