

WELCOME

Thank you for filling out this form completely. Our goal is to help you achieve and maintain excellent dental health. The better we communicate, the better we can care for your needs. If you have any questions, we'll be glad to help! For your convenience you may use your keyboard and mouse to complete this form. Then print the form and fax, mail or bring it with you to your next appointment. Our fax number is (616) 669-2964 and our mail address is Hudsonville Dental, 3250 Central Blvd., Hudsonville, MI 49426

1. ABOUT YOU

Name: _____ Occupation: _____
I prefer to be called: _____ Birthdate: _____ S.S. # _____
Spouse: _____ Occupation: _____
Address: _____ City: _____ Zip Code: _____
 Male Female Single Married Divorced Widowed Separated
Home # : _____ Work # : _____ Cell # : _____
E-mail address _____

2. DENTAL INSURANCE

PRIMARY CARRIER	SECONDARY CARRIER
Ins. Co. _____	Ins. Co. _____
Employee: _____	Employee: _____
Employer: _____ Group # : _____	Employer: _____ Group # : _____
Date of Birth. _____ Date employed _____	Date of Birth _____ Date employed _____
Employee S. S. # : _____	Employee S.S. # : _____

GETTING TO KNOW YOU

Other family members / relatives seen by us: _____
Whom may we thank for referring you? _____
How did you hear about us? Family/Friend Phone book Advance Sign /Drive By Hi Neighbor

CONSENT FOR TREATMENT

1. I hereby authorize Dr. Dykstra and staff to take X-rays, study models, photos, and other diagnostic aids deemed appropriate by Dr. to make a thorough diagnosis of my dental needs.
2. Upon such diagnosis, I authorize Dr. Dykstra to perform all recommended treatment mutually agreed upon.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at time of service -unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a finance charge of 12% APR will be added to my account.

Patient's Signature _____

Date: _____

Patient Name

DENTAL HISTORY

Patient Account No.

Medical Alert

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.

What is the reason for your visit today? _____

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

What was done at your last dental visit? _____

Previous Dentist's Name _____

Address _____ State _____ Zip _____

Telephone _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? YES NO

If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold? YES NO

Sweets? YES NO

Biting or Chewing? YES NO

Have you noticed any mouth odors or bad tastes? YES NO

Do you frequently get cold sores, blisters or any other oral lesions? YES NO

Do your gums bleed or hurt? YES NO

Have your parents experienced gum disease or tooth loss? YES NO

Have you noticed any loose teeth or change in your bite? YES NO

Does food tend to become caught in between your teeth? YES NO

If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep? YES NO

Bite your lips or cheeks regularly? YES NO

Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) YES NO

Mouth breathe while & wake or asleep? YES NO

Have tired jaws, especially in the morning? YES NO

Smoke/chew tobacco? YES NO

Have you ever had:

Orthodontic treatment? YES NO

Oral surgery? YES NO

Periodontal treatment? YES NO

Your teeth ground or the bite adjusted? YES NO

A bite plate or mouth guard? YES NO

A serious injury to the mouth or head? YES NO

If so, please describe, including cause _____

Have you experienced:

Clicking or popping of the jaw? YES NO

Pain? (joint, ear, side of face) YES NO

Difficulty in opening or closing the mouth? YES NO

Difficulty in chewing on either side of the mouth? YES NO

Headaches, neckaches or shoulder aches? YES NO

Sore muscles (neck, shoulders)? YES NO

Are you satisfied with your teeth's appearance? YES NO

Would you like to keep all of your teeth all of your life? YES NO

Do you feel nervous about having dental treatment? YES NO

If so, what is your biggest concern? _____

Have you ever had an upsetting dental experience? YES NO

If yes, please describe _____

Is there anything else about having dental treatment that you would like us to know?

If yes, please describe _____

Patient Name

MEDICAL HISTORY

Patient Account No.

Medical Alert

1. Have you been under the care of a medical doctor during the past two years? YES NO

If yes, for what? _____

Physician's Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

2. Have you taken any medication or drugs during the past two years? YES NO

3. Are you taking any medication, drugs or pills now? YES NO

If yes, please list name and dosage _____

4. Are you aware of having an allergic (or adverse reaction) to any medication or substance? YES NO

If yes, please list: _____

5. Have you been a patient in the hospital during the past five years? YES NO

6. Indicate which of the following you have had, or have at present. Check if using your keyboard or a pen, "yes" or "no" to each item.

- | | | |
|---|---|---|
| Heart (Surgery, Disease, Attack) ... <input type="checkbox"/> YES <input type="checkbox"/> NO | Ulcers <input type="checkbox"/> YES <input type="checkbox"/> NO | Hepatitis A (infectious) B (serum) <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Chest Pain <input type="checkbox"/> YES <input type="checkbox"/> NO | Diabetes <input type="checkbox"/> YES <input type="checkbox"/> NO | Venereal Disease <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Congenital Heart Disease <input type="checkbox"/> YES <input type="checkbox"/> NO | Thyroid Problems <input type="checkbox"/> YES <input type="checkbox"/> NO | A.I.D.S. <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Heart Murmur <input type="checkbox"/> YES <input type="checkbox"/> NO | Glaucoma <input type="checkbox"/> YES <input type="checkbox"/> NO | H.I.V. Positive <input type="checkbox"/> YES <input type="checkbox"/> NO |
| High Blood Pressure <input type="checkbox"/> YES <input type="checkbox"/> NO | Contact lenses <input type="checkbox"/> YES <input type="checkbox"/> NO | Cold Sores/Fever Blisters <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Mitral Valve Prolapse <input type="checkbox"/> YES <input type="checkbox"/> NO | Emphysema <input type="checkbox"/> YES <input type="checkbox"/> NO | Blood Transfusion <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Artificial Heart Valve <input type="checkbox"/> YES <input type="checkbox"/> NO | Chronic Cough <input type="checkbox"/> YES <input type="checkbox"/> NO | Hemophilia <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Heart Pacemaker <input type="checkbox"/> YES <input type="checkbox"/> NO | Tuberculosis <input type="checkbox"/> YES <input type="checkbox"/> NO | Sickle Cell Disease <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Rheumatic Fever <input type="checkbox"/> YES <input type="checkbox"/> NO | Asthma <input type="checkbox"/> YES <input type="checkbox"/> NO | Bruise Easily <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Arthritis/Rheumatism <input type="checkbox"/> YES <input type="checkbox"/> NO | Hay Fever <input type="checkbox"/> YES <input type="checkbox"/> NO | Liver Disease <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Cortisone Medicine <input type="checkbox"/> YES <input type="checkbox"/> NO | Latex Sensitivity <input type="checkbox"/> YES <input type="checkbox"/> NO | Yellow Jaundice <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Swollen Ankles <input type="checkbox"/> YES <input type="checkbox"/> NO | Allergies or Hives <input type="checkbox"/> YES <input type="checkbox"/> NO | Neurological Disorders <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Stroke <input type="checkbox"/> YES <input type="checkbox"/> NO | Sinus Trouble <input type="checkbox"/> YES <input type="checkbox"/> NO | Epilepsy or Seizures <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Diet (Special/ Restricted) <input type="checkbox"/> YES <input type="checkbox"/> NO | Radiation Therapy <input type="checkbox"/> YES <input type="checkbox"/> NO | Fainting or Dizzy Spells <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Artificial Joints (hip, knee, etc.) <input type="checkbox"/> YES <input type="checkbox"/> NO | Chemotherapy. <input type="checkbox"/> YES <input type="checkbox"/> NO | Nervous/Anxious <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Kidney Trouble <input type="checkbox"/> YES <input type="checkbox"/> NO | Tumors <input type="checkbox"/> YES <input type="checkbox"/> NO | Psychiatric/Psychological Care <input type="checkbox"/> YES <input type="checkbox"/> NO |

7. Do you use more than two pillows to sleep? YES NO

8. Have you lost or gained more than 10 pounds in the past year? YES NO

9. Do you have or have you had any disease, condition, or problem not listed? YES NO

If yes, please list: _____

10. Women. Are you: **Pregnant?** YES ___ Months NO **Nursing?** YES NO **Taking birth control pills?** YES NO

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient /Guardian Signature _____ Date _____

History Review

Dentist Signature _____ Date _____