Welcome

Kurt E. Schabes, D.D.S. (616) 676-2223

About You

Today's Date: ____________________ E-mail Address: ________________________________

Name: ____ I prefer to be called: ____________________ ❑ Male ❑ Female
Last First Mi Mr Mrs Ms Dr

Birthdate: ___/___/___ Age: ______ Social Security #: ____________________ ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home Address: ____
Street City State Zip

Home Phone #: (_____)__________ Pager/Car #: (_____)__________ Work Phone #: (_____)__________ Ext: ____ Driver's License #: __________

Where & when are 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 Orthodontic Coverage? ❑ Yes ❑ No Medical 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 Orthodontic Coverage? ❑ Yes ❑ No Medical 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

CONTINUED ON BACK

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
Orthdontist 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 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 ____________

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