Patient Information

Name_____ Date_____

Address_____ Apt#_____

City_____ State_____ Zip_____

Telephone (Home)_____ (Work)_____ (Cell)_____

e-Mail_____

Date of Birth_____ Marital Status_____ Social Security Number_____

Occupation_____ Employer_____

Other family members at this office ❑ yes ❑ no_____

Referred by_____

Spouse or guardian_____

Address (if different than above)_____ Apt#_____

City_____ State_____ Zip_____

Telephone (Home)_____ (Work)_____ (Cell)_____

Financial Information

Primary Insurance Carrier

Employed By_____ Dental Ins. Co._____

Employee_____ Employee Date of Birth_____

Employee SSN_____ Union/Local #_____ Group #_____

Secondary Insurance Carrier

Employed By_____ Dental Ins. Co._____

Employee_____ Employee Date of Birth_____

Employee SSN_____ Union/Local #_____ Group #_____

Person Responsible for Paying This Account (if different than above)_____

Address_____ Apt#_____

City_____ State_____ Zip_____

Telephone (Home)_____ (Work)_____ (Cell)_____

Fowlerville Family Dentistry

Brian J. Petersburg DDS

Brian K. Giammalva DDS

Medical History

Please check if you have had or have any of the following:

❑ yes ❑ no Chest pain, shortness of breath
❑ yes ❑ no Bleeding problems or blood thinning medications
❑ yes ❑ no Headaches
❑ yes ❑ no Heart disease, heart murmur, rheumatic fever, prosthetic heart valve, mitral valve prolapse, or stent
❑ yes ❑ no Pacemaker
❑ yes ❑ no Heart attack
❑ yes ❑ no Hepatitis A, B, C, or liver disease
❑ yes ❑ no TB, asthma, or lung disease
❑ yes ❑ no High blood pressure, hypertension
❑ yes ❑ no Adverse reaction to local anesthetic
❑ yes ❑ no Diabetes
❑ yes ❑ no Thyroid problems
❑ yes ❑ no Tumors

❑ yes ❑ no Psychiatric/neurological care
❑ yes ❑ no Kidney or bladder disease
❑ yes ❑ no Sexually transmitted disease
❑ yes ❑ no HIV positive, AIDS
❑ yes ❑ no Are you now pregnant?
❑ yes ❑ no Birth control medication
❑ yes ❑ no Stroke or TIA
❑ yes ❑ no Seizure disorders
❑ yes ❑ no Artificial joint
❑ yes ❑ no Alcoholism, chemical dependency
❑ yes ❑ no Arthritis
❑ yes ❑ no HPV (human papilloma virus)
❑ yes ❑ no Excessive daytime sleepiness?
❑ yes ❑ no Do you snore?

❑ yes ❑ no Cancer If yes, what type?_____
Did you receive radiation / chemotherapy? ❑ yes ❑ no
❑ yes ❑ no Are there any other medical conditions that you feel we should be aware of?
_____

Please list your current medications, **and reason you are taking them**:

_____
_____
_____
_____

Please list any allergies you are currently aware of:

_____
_____
_____

Are you now taking, or have you taken in the past, bisphosphonates? ❑ yes ❑ no
These include: Fosamax, Didronel, Skelid, Bonefos, Aredia, Zometa, Actonel, Boniva

Physician's name_____
Address_____
Telephone_____
Date of last medical exam_____
Have you been a patient in a hospital during the past two years? ❑ yes ❑ no
If yes, what for?_____
Have you ever used tobacco products? ❑ yes ❑ no
If yes, do you currently use them?___How frequently?_____
Have you recently lost weight unintentionally? ❑ yes ❑ no
Are you currently on a prescribed diet? ❑ yes ❑ no
If yes, for what reason?_____
Have you ever needed premedication prior to dental appointments? ❑ yes ❑ no

Dental History

Date of last dental visit_____
Date of last dental cleaning_____
Dentist's Name_____
Address_____
Telephone_____

Have you come to this office for relief of pain? ❑ yes ❑ no
If yes, where is the pain?_____
Do you have unreplaced missing teeth? ❑ yes ❑ no
If yes, why have you not replaced them?_____
Do you have difficulty swallowing? ❑ yes ❑ no
Do your gums bleed when brushing your teeth? ❑ yes ❑ no
Have you ever been told you have periodontal disease? ❑ yes ❑ no
Is any part of your mouth sensitive to temperature or pressure? ❑ yes ❑ no
If yes, which part?_____
Does food catch between your teeth? ❑ yes ❑ no
If yes, where?_____
Do you have any unpleasant taste or odor in your mouth? ❑ yes ❑ no
Do you ever get cold sores or canker sores? ❑ yes ❑ no
Do you ever feel that you have a dry mouth? ❑ yes ❑ no
Are you dissatisfied with your teeth or their appearance? ❑ yes ❑ no
In the past, have you required a lot of dental work? ❑ yes ❑ no
Have you had any serious trouble associated with any previous dental treatment? ❑ yes ❑ no
If yes, briefly describe_____
Have you ever had a bad experience in the dental office? ❑ yes ❑ no
How do you feel about going to the dentist (circle the best answer):
No Problem Apprehensive Scared

Occlusal / Sleep History

Do you wear complete and/or partial dentures? ❑ yes ❑ no
Have you had prior orthodontic treatment (braces)? ❑ yes ❑ no
Have you ever been diagnosed with TMJ/TMD or wear a bite splint/night guard? ❑ yes ❑ no
Are you aware of any problems with snoring? ❑ yes ❑ no
Have you ever been diagnosed with sleep apnea? ❑ yes ❑ no
Do you have excessive daytime sleepiness or fatigue? ❑ yes ❑ no
Are you aware of clenching or grinding your teeth? ❑ yes ❑ no
Do you have chronic headaches or a tight or stiff neck? ❑ yes ❑ no
Do you ever wake up with sore teeth or pain in your jaw joint or the sides of your face (in and about the ears)? ❑ yes ❑ no
Do you ever have a clicking jaw joint? ❑ yes ❑ no
Have you ever experienced an inability to move your jaw or open widely? ❑ yes ❑ no
Which side of your mouth do you chew on? Right Left Both

Patient_____ **Date**_____

Doctor_____ **Date**_____

Update _____Date_____

Update _____Date_____

Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of the changes, it is not always possible. Therefore, it is your responsibility to know your individual coverage. Failing to do so will result in you, the patient, being responsible for all costs incurred. Please remember that your insurance policy is between you and your insurance company, not between the insurance company and your dentist. Payment is required at the time of service; however, if insurance is involved, payment will be expected on the copay. On major work, at least half payment is required at time of service. **If for any reason insurance does not pay in a reasonable time, payment will be expected from the patient**.

Most importantly, we are here to help in any way we can, and look forward to meeting your dental needs. Again, welcome to our practice!

I accept and understand the patient responsibilities outlined above, and attest that the information provided on this form is correct to the best of my knowledge:

Patient_____ **Date**_____

Authorization to pay benefits to dentist:

I hereby authorize payment directly to the below named dentist of the benefit otherwise payable to me for his services as described, but not to exceed the reasonable and customary charges for those services.

Patient_____ **Date**_____

Authorization to release information:

I authorize the below named dentist to release any information relating to my treatment for insurance purposes, including radiographs (x-rays) and study models.

Patient_____ **Date**_____