GREAT LAKES FAMILY DENTISTRY
Patient Registration Form

ID: ________ **Chart ID:** ________________

First Name: ______________ Last Name: ______________ Middle Initial: ____

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name: ______________
☐ Other

Patient Information

Address: ______________ Address 2: ______________

City, State: ______________ Zip: ________

Home Phone: ________ Work Phone: ________ Ext: ____ Mobile: ________

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date: ________ Age: ____ Soc Sec: ________ Driver's Lic: ________

Email: ______________ ☐ I would like to receive correspondences via email

Section 2

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Medicaid ID: ________ Preferred Dentist: ________

Employer ID: ________ Preferred Pharmacy: ________

Carrier ID: ________ Preferred Hygienist: ________

Section 3

Occupation: ________

Hobby: ________

Volunteer: ________

Referral: ________

Kids - School: ________

Kids - College: ________

Responsible Party (if someone other than the patient)

First Name: ______________ Last Name: ______________ Middle Initial: ____

Address: ______________ Address 2: ______________

City, State: ______________ Zip: ________

Home Phone: ________ Work Phone: ________ Ext: ____ Mobile: ________

Birth Date: ________ Soc Sec: ________ Driver's Lic: ________

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

Primary Insurance Information

Name of Insured: ______________ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Social Security: ________ Insured Birth Date: ________

Employer: ______________ Ins. Company: ______________

Address: ______________ Address: ______________

Address 2: ______________ Address 2: ______________

City, State, Zip: ______________ City, State, Zip: ______________

Rem. Benefits: ________ .00 Rem. Deduct: ________ .00

Secondary Insurance Information

Name of Insured: ______________ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Social Security: ________ Insured Birth Date: ________

Employer: ______________ Ins. Company: ______________

Address: ______________ Address: ______________

Address 2: ______________ Address 2: ______________

City, State, Zip: ______________ City, State, Zip: ______________

Rem. Benefits: ________ .00 Rem. Deduct: ________ .00

GREAT LAKES FAMILY DENTISTRY
Dental History Form

First Name: ____________________ Last Name: ____________________

Previous Dentist: ____________________ How long: ____________________

Most recent dental exam: ____________________ Most recent x-rays: ____________________

Most recent dental treatment: ____________________

How often do you have your teeth cleaned? ☐ 3 months ☐ 4 months ☐ 6 months ☐ 9 months ☐ 1 year or more

What is your immediate dental concern? ____________________

Please answer by circling YES or NO to the following:

1. Unhappy with the appearance of your teeth	YES	NO
2. Unfavorable dental experiences	YES	NO
3. Dental fears	YES	NO
4. Problems with effectiveness or bad reactions to dental anesthetics	YES	NO
5. Orthodontic treatment ***(Date ____________________)***	YES	NO
6. Periodontal (gum) treatment ***(Date ____________________)***	YES	NO
7. Avoid brushing any part of your mouth	YES	NO
8. Have gums that bleed when brushing or flossing	YES	NO
9. Have teeth that are sensitive to hot or cold	YES	NO
10. Have sore or painful teeth	YES	NO
11. Have a burning sensation in your mouth	YES	NO
12. Have difficulty swallowing	YES	NO
13. Have an unpleasant taste or odor in your mouth	YES	NO
14. Dry mouth, throat, and/or eyes	YES	NO
15. Jaw problems (temporomandibular joint)	YES	NO
16. Difficulty in opening your mouth widely	YES	NO
17. Stiff neck muscles	YES	NO
18. Awaken with an awareness of your teeth or jaws	YES	NO
19. Have tension headaches	YES	NO
20. Clench or grind your teeth	YES	NO
21. Lost any teeth	YES	NO
22. Wear a bite splint, night guard, orthodontic retainer or sleep apnea appliance	YES	NO

Supplemental Denture History

If you are wearing a removable partial or complete denture, please complete the following:	YES	NO
1. Has your present denture been relined? ***(Date ____________________)***	YES	NO
2. Is your present denture a problem? ***(Describe ____________________)***	YES	NO
3. Are you satisfied with appearance? ***(If no, please explain ____________________)***	YES	NO
4. Are you satisfied with comfort? ***(If no, please explain ____________________)***	YES	NO
5. Are you satisfied with chewing ability? ***(If no, please explain ____________________)***	YES	NO
6. When did you receive your first partial or complete denture? ***(Date ____________________)***	YES	NO
7. How long have you worn your present denture? ***(Date ____________________)***	YES	NO

6543 28th Avenue Hudsonville, MI 49426

616-669-1225

GREAT LAKES FAMILY DENTISTRY
Medical History Form

Patient Name: ______________________ Birth Date: ______________________ Date Created: ______________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking are important for us to be aware of.

Question	Answer	If yes
Are you under a physician's care now?	◯ Yes ◯ No	If yes: __________
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes: __________
Have you ever had a serious head/neck injury?	◯ Yes ◯ No	If yes: __________
Are you taking any medications, pills or drugs?	◯ Yes ◯ No	If yes: __________
Do you take/have you taken Phen-Fen or Redux?	◯ Yes ◯ No	If yes: __________
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes: __________
Are you on a special diet?	◯ Yes ◯ No	If yes: __________
Do you use tobacco?	◯ Yes ◯ No	If yes: __________
Do you use controlled substances?	◯ Yes ◯ No	If yes: __________

Women, are you....

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Other? Please Specify: __________

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics __________

Do you have/have you had any of the following?

Condition	Yes/No	Condition	Yes/No	Condition	Yes/No	Condition	Yes/No
AIDS/HIV Positive	◯ Yes ◯ No	Coritsone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy/Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors of Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
						Yellow Jaundice	◯ Yes ◯ No

Have you ever had any serious illness no listed above? ◯ Yes ◯ No If yes: __________

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent of Guardian: ______________________ **Date:** __________