Kalamazoo Family & Cosmetic Dentistry
STEVEN RAY, D.M.D.

Name: _____
Last First MI Preferred Name

Address: _____ City:_____ State:_____ Zip:_____

Sex: M F Age: _____ DOB: _____ SSN: _____

Cell Phone: _____ Home Phone: _____

Email: _____ Work Phone: _____

Employer: _____ Occupation: _____

Marital Status: Single Married Divorced Widowed Separated Domestic Partner

Do you prefer to be contacted by our office via email or phone? (Please circle preference)

How did you hear about us? _____

Insurance – Primary

Subscriber Name: _____ Relationship to patient: _____Subscriber DOB: _____

Subscriber SSN/ID: _____ Subscriber Employer: _____

Insurance Company Name: _____Group # _____

Insurance – Secondary

Subscriber Name: _____ Relationship to patient: _____Subscriber DOB: _____

Subscriber SSN/ID: _____ Subscriber Employer: _____

Insurance Company Name: _____Group # _____

Assignment and Release
I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Kalamazoo Family Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorized the use of this signature on all insurance submissions.

Responsible Party Signature: _____

Relationship: _____ Date: _____

Name: _____

Date: _____

Medical History

Do you have a personal physician? Yes No
Physician's Name:
_____
Physician's 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 use tobacco in any form? Yes No
Have you had any metal rods, pins or implants placed? Yes No
Are you taking any medications? Yes No
Please list each one: _____

Have you ever had any surgical procedures? Yes No
Please list each one: _____

Please circle any condition(s) you have, have had, or have been treated for:

Abnormal Bleeding	Epilepsy	Liver Disease
Alcohol Abuse	Facial Surgery	Low Blood Pressure
Allergies	Fainting Spells	Mitral Valve Prolapse
Anemia	Fever Blisters/ Cold Sores	Pace Maker
Angina Pectoris	Frequent Headaches	Psychiatric Conditions
Arthritis	Glaucoma	Radiation Therapy
Artificial Heart Valve	HIV / AIDS	Rheumatic Fever
Asthma	Heart Attack	Seizures
Blood Transfusion	Heart Murmer	Sexually Transmitted Disease
Cancer	Heart Surgery	Shingles
Chemotherapy	Hemophilia	Sickle Cell Disease
Colitis	Hepatitis A	Sinus Problems
Congenital Heart Defect	Hepatitis B	Stroke
Diabetes	Hepatitis C	Thyroid Problems
Difficulty Breathing	High Blood Pressure	Tuberculosis
Drug Abuse	Joint Replacement	Ulcers
Emphysema	Kidney Problems	

Allergies?

Aspirin	Latex
Codeine	Metals
Dental Anesthetics	Penicillin
Erythromycin	Tetracycline
Other:	

If Female, Please Answer:

Are you taking any birth control medications? Yes No

Are you or could you be pregnant? Yes No

If yes, how many weeks? _____

Are you nursing? Yes No

Name: _____

Date: _____

Dental History

How may we help you today? _____

Are you in any pain? If so, explain. _____

Do you require antibiotics before dental treatment? *Circle one* Yes No
Have you ever had gum treatment? Yes No
Do you know or have you had any pain/discomfort in your jaw joint (TMJ)? Yes No
Do you clench or grind your teeth? Yes No
Do you have headaches, earaches, or neck pain? Yes No
Do you like your smile? Yes No
Are you happy with the color of your teeth? Yes No
Do you like the shape / look of your teeth? Yes No
Is there anything you would like to change about your smile? If so, explain: _____

_____

Do your gums bleed, feel tender or irritated? Yes No
How many times do you floss per week? _____
Do you have any loose or shifting teeth? Yes No
Do you experience any pain when you chew? Yes No
Are your teeth sensitive to Heat? Cold? Sweets? Pressure? Anything else? _____
Have you ever had a serious / difficult time with any dental treatment? Yes No
Have you ever had an unfavorable dental experience? Yes No
Are you apprehensive about dental treatment? Yes No
Do you want dental anesthetic used? Yes No
Have you ever had problems with dental anesthetic? Yes No

When was your last dental exam? _____ Cleaning? _____

Why did you leave your previous dentist? _____

Is there anything we can do to make your dental visit easier? _____

_____

Here at Kalamazoo Family & Cosmetic Dentistry we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below you would like our friendly staff to discuss with you during your visit.

Tooth Whitening	Veneers	Crown / Bridge
Invisalign	Smile Makeover	Dental Implants
Six Month Smiles (braces)	Bonding	Night guard/ Bite Splint
Sealants	Partial/ Dentures	Athletic Mouthguard