



Brock Arms, D.D.S. & John Kempton, D.D.S. 300 Paluster Street, Cadillac, MI 49601

**PERSONAL INFORMATION**

PATIENT NAME: \_\_\_\_\_

PREFERS TO BE ADDRESSED AS \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

HOME PHONE ( \_\_\_\_\_ ) \_\_\_\_\_

CELL PHONE ( \_\_\_\_\_ ) \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_

BIRTH DATE \_\_\_\_\_ SS# \_\_\_\_\_

DRIVERS LICENSE NUMBER \_\_\_\_\_

AGE \_\_\_\_\_ MALE \_\_\_\_\_ FEMALE \_\_\_\_\_ MARTIAL STATUS \_\_\_\_\_ (M/S)

PATIENT EMPLOYER \_\_\_\_\_

WORK PHONE \_\_\_\_\_

SPOUSE/PARENT NAME \_\_\_\_\_

**WHOM CAN WE THANK FOR REFERRING**

**YOU TO OUR OFFICE?** \_\_\_\_\_

PRIMARY DENTAL BENEFIT CO. \_\_\_\_\_

INSURED NAME \_\_\_\_\_ SS# \_\_\_\_\_ BIRTH DATE \_\_\_\_\_

ID# \_\_\_\_\_ GROUP # \_\_\_\_\_

SECONDARY DENTAL BENEFIT CO. \_\_\_\_\_

INSURED NAME \_\_\_\_\_ SS# \_\_\_\_\_ BIRTH DATE \_\_\_\_\_

ID # \_\_\_\_\_ GROUP # \_\_\_\_\_

(WE WILL BILL YOUR BENEFITS AS A COURTESY)

**IN THE EVENT OF AN EMERGENCY, WHO SHOULD WE CONTACT?**

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

HOME PHONE # \_\_\_\_\_ WORK PHONE # \_\_\_\_\_

WHAT MOTIVATED YOU TO CONTACT US \_\_\_\_\_

**DENTAL HISTORY**

- Have there been any injuries to the face, mouth or teeth? No \_\_\_\_\_ If yes please tell us: \_\_\_\_\_
- Have you had or do you presently have any of the following habits? Thumb or finger sucking \_\_\_\_\_ Lip Biting \_\_\_\_\_  
Snoring \_\_\_\_\_ Grinding of teeth at night \_\_\_\_\_ Mouth Breathing \_\_\_\_\_ Other \_\_\_\_\_
- Have you been informed of any missing or extra permanent teeth? Yes \_\_\_\_\_ No \_\_\_\_\_
- Are you aware of sores, lumps or irritated areas in the mouth? Yes \_\_\_\_\_ No \_\_\_\_\_
- Have you ever been treated for: TMJ \_\_\_\_\_ Periodontal Disease \_\_\_\_\_ Other \_\_\_\_\_  
If so, by whom? \_\_\_\_\_ When? \_\_\_\_\_
- Do you have any concerns? No \_\_\_\_\_ If Yes please tell us: \_\_\_\_\_
- Do you feel frightened or anxious regarding dental treatment? No \_\_\_\_\_ If Yes please tell us: \_\_\_\_\_
- Are you concerned about the appearance of your teeth? Yes \_\_\_\_\_ No \_\_\_\_\_
- Is there anything you would like to change about your smile? Yes \_\_\_\_\_ No \_\_\_\_\_  
If so what? \_\_\_\_\_
- What aspect of dental treatment is most important to you? Quality \_\_\_\_\_ Cost \_\_\_\_\_ Discomfort \_\_\_\_\_
- What are your dental priorities? \_\_\_\_\_
- Last dental visit \_\_\_\_\_ When \_\_\_\_\_ Dentist Name \_\_\_\_\_
- Please share your reason for changing dentist; it may help us serve you better. \_\_\_\_\_
- To ensure your initial visit at LifeSMILES dentistry is a great experience, please share any questions or concerns you would like us to know about.

# SYSTEMIC INFLAMMATORY MEDICAL HISTORY

## PLEASE INDICATE IF YOU HAVE EXPERIENCED ANY OF THE FOLLOWING:

Yes ___ No ___ COPD	Yes ___ No ___ Lack of Exercise	Yes ___ No ___ Pregnant Now
Yes ___ No ___ Diabetes	Yes ___ No ___ Osteoporosis	Yes ___ No ___ Rheumatoid Arthritis
Yes ___ No ___ Heart Attack	Yes ___ No ___ Past Miscarriage	Yes ___ No ___ Smoker (past 3 years)
Yes ___ No ___ High Carb Diet	Yes ___ No ___ Periodontal Disease	Yes ___ No ___ Stroke / TIA
Yes ___ No ___ High Stress	Yes ___ No ___ Planning a Family	Yes ___ No ___ GI Disorders/IBS/Crohn's
Yes ___ No ___ Hypertension	Yes ___ No ___ Poor Sleep Quality	

## PLEASE INDICATE IF ANY FAMILY HISTORY APPLIES:

Has a parent or grandparent had heart disease, heart attack, or stroke?	Yes ___ No ___
Has a parent or grandparent had diabetes?	Yes ___ No ___
Has a parent or grandparent had periodontal disease?	Yes ___ No ___
Has a parent or grandparent had COPD?	Yes ___ No ___
Has a parent or grandparent had cancer?	Yes ___ No ___

## GENERAL MEDICAL HISTORY:

Yes ___ No ___ ADD/ADHD	Yes ___ No ___ Endocarditis	Yes ___ No ___ Cancer [Type _____]
Yes ___ No ___ AIDS or HIV+	Yes ___ No ___ Epilepsy	Yes ___ No ___ Heart Surgery [Date _____]
Yes ___ No ___ Alcohol Dependency	Yes ___ No ___ Fainting Spells	Yes ___ No ___ Hepatitis [Type _____]
Yes ___ No ___ Allergies	Yes ___ No ___ GERD	Yes ___ No ___ Mitral Valve Prolapse
Yes ___ No ___ Anemia	Yes ___ No ___ Glaucoma	Yes ___ No ___ Pacemaker
Yes ___ No ___ Arthritis	Yes ___ No ___ Headaches	Yes ___ No ___ Prosthetic Joint
Yes ___ No ___ Artificial Heart Valve	Yes ___ No ___ Heart Angina	Yes ___ No ___ Psychiatric Care
Yes ___ No ___ Asthma	Yes ___ No ___ Heart Murmur	Yes ___ No ___ Radiation Therapy
Yes ___ No ___ Birth Control Meds	Yes ___ No ___ Herpes [oral]	Yes ___ No ___ Rheumatic Fever
Yes ___ No ___ Blood Disorders	Yes ___ No ___ Jaw Clicks/noise	Yes ___ No ___ Thyroid Disorder
Yes ___ No ___ Congenital Heart Valve	Yes ___ No ___ Kidney Disease	Yes ___ No ___ Tonsils Removed
Yes ___ No ___ Drug Dependency	Yes ___ No ___ Liver Disease	Yes ___ No ___ Tuberculosis
Yes ___ No ___ Dry Mouth	Yes ___ No ___ Low Blood Pressure	Yes ___ No ___ Ulcers
Yes ___ No ___ Earaches	Yes ___ No ___ Lung Disease	Yes ___ No ___ Wear a CPAP -- Every night:
Yes ___ No ___ Emotional Concerns		Yes ___ No

Other \_\_\_\_\_

## ALLERGY REPORT:

Yes \_\_\_ No \_\_\_ Allergic to Antibiotics / List: \_\_\_\_\_

Yes \_\_\_ No \_\_\_ Allergic to Metals. List if so: \_\_\_\_\_

Yes \_\_\_ No \_\_\_ Allergic to Latex      Yes \_\_\_ No \_\_\_ Allergic to other Medications / List: \_\_\_\_\_

## GENERAL HEALTH:

Yes \_\_\_ No \_\_\_ Are you in good general health now?      Yes \_\_\_ No \_\_\_ Do you feel well?

Yes \_\_\_ No \_\_\_ Are you under the regular care of a physician at this time?      Date of last physical: \_\_\_\_\_

Reason for regular medical care, if required: \_\_\_\_\_

Name of MD: \_\_\_\_\_ Phone number: \_\_\_\_\_

Have you had a serious illness, been hospitalized? Explain briefly \_\_\_\_\_

Have you had chemo or radiation therapy for cancer? How long ago? \_\_\_\_\_

Yes \_\_\_ No \_\_\_ Have you used tobacco products in the past.      Yes \_\_\_ No \_\_\_ Currently Nursing or Pregnant.

Yes \_\_\_ No \_\_\_ Have you had a joint replacement in the past two years.

- ❖ Yes \_\_\_ No \_\_\_ **Been advised by MD to take antibiotics before dental appointment.**
- ❖ **Please provide a list of current medications**

**Other important medical considerations:** \_\_\_\_\_

I consent to dental and oral surgical procedures "agreed upon". I will assume responsibility for fees associated with these procedures. To the best of my knowledge, all information I have provided is correct. I commit to informing you of any changes to my health at my next appointment.

Signature of Patient/Parent: \_\_\_\_\_ Date \_\_\_\_\_ Signature of Dentist \_\_\_\_\_