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: _____________________________________

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

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

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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