Canton Dental Clinic

Dr. Gordon Schulte Dr. Lee Gertsen Dr. Kim Suga

Patient Information

Date__________

Patient's Name ____ Age ___ Birthday _____ Sex: M ☐ F ☐
Last First Middle

Mailing Address ____ How long at this address? ________
Street City State Zip

Home Phone ( ) __________ Cell ( ) ___________ Email ____________________ Social Security #____________

Employer _______________ Occupation ______________ Work Phone ( ) _________ School ______________

Spouse's Name ______________________ Birthdate ______________ Social Security # ____________________

Employer ________________ Occupation _______________ Work Phone (___) __________________________

Whom may we thank for referring you? ____

Responsible Party Information (If parent is responsible for account)

Father's Name ___________________ Birthdate ______________ Social Security # _____________________

Address ____ Home Phone (___) ____________________

Employer ___________________ Occupation _________________ Work Phone (___) ____________________

Mother's Name ____________________ Birthdate _______________ Social Security # _____________________

Address ____ Home Phone (___) ____________________

Employer __________________ Occupation __________________ Work Phone (___) ____________________

Do you have Dental Insurance? Yes No

Primary Insurance Company:

Subscriber's Name ____________________________

Subscriber's Address ___________________________

Subscriber's Soc. Sec. # _________________________

Insurance Company ____________________________

Group No. _______________ ID No. _____________

Insurance Co. Address __________________________

Telephone (______)______________________

Subscriber's Employer/Address____________________

____

Do you have dual coverage? Yes ☐ No ☐ If yes:

Subscriber's Name ______________________________

Subscriber's Soc. Sec. # ___________________________

Insurance Company______________________________

Group No. ______________ ID No. ______________

Ins. Co. Address_________________________________

Telephone (______)____________________

Subscriber's Employer/Address ____________________

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Is patient covered under Medicaid? # __________________

I have read and answered all questions to the best of my knowledge. I authorize and

Authorization and Release

request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions. I understand that where appropriate, credit bureau reports may be obtained.

Signature of patient (or parent if minor)____________________**(required)** Date ________________

Prefered Method of Payment: cash ☐ check ☐ credit card ☐

Payment is due in full at time of treatment unless prior arrangements have been approved. 5% cash discount

(over please)

Please complete if you are a “new” patient

Reason for today’s visit ______________________________

____

Former Dentist ____________________

City/State ____________________

Date of last dental visit __________

For what service? __________

Date of last dental X-rays __________

Place a mark “Yes” or “No” to indicate if you have had any of the following:

Bad breath	☐ Yes ☐ No
Bleeding gums	☐ Yes ☐ No
Blisters on lips or mouth	☐ Yes ☐ No
Burning sensation on tongue	☐ Yes ☐ No
Smoking/tobacco habit	☐ Yes ☐ No
Clicking or popping jaw	☐ Yes ☐ No
Dry mouth	☐ Yes ☐ No
Fingernail biting	☐ Yes ☐ No
Food collection between the teeth	☐ Yes ☐ No
Grinding teeth	☐ Yes ☐ No
Gums swollen or tender	☐ Yes ☐ No
Jaw pain or tiredness	☐ Yes ☐ No
Lip or cheek biting	☐ Yes ☐ No
Loose teeth or broken fillings	☐ Yes ☐ No
Mouth pain, brushing	☐ Yes ☐ No
Pain around ear	☐ Yes ☐ No
Periodontal treatment	☐ Yes ☐ No
Sensitivity to cold	☐ Yes ☐ No
Sensitivity to heat	☐ Yes ☐ No
Sensitivity to sweets	☐ Yes ☐ No
Sensitivity when biting	☐ Yes ☐ No
Sores or growths in your mouth	☐ Yes ☐ No

How often do you floss? __________

How often do you brush? __________

Do you drink purified water? __________

Medical History

Physician’s Name ______________________________ Date of last visit __________

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe ____________________

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates ____________________

Have you ever been told you cannot give blood? __________ Reason

____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

AIDS	☐ Yes ☐ No
Abnormal bleeding from a cut	☐ Yes ☐ No
Anemia	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No
Asthma	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No
Cancer	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No
Cortisone Treatments	☐ Yes ☐ No
Cough, Persistent	☐ Yes ☐ No
Cough up Blood	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No
Fainting	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No
Headaches	☐ Yes ☐ No
Heart Murmur	☐ Yes ☐ No
Heart Problems Describe ____________	☐ Yes ☐ No
Hemophilia	☐ Yes ☐ No
Hepatitis -Type ________	☐ Yes ☐ No
Herpes	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No
HIV Positive	☐ Yes ☐ No
Jaundice	☐ Yes ☐ No
Kidney Disease	☐ Yes ☐ No
Liver Disease	☐ Yes ☐ No
Mitral Valve Prolapse	☐ Yes ☐ No
Parkinson Disease	☐ Yes ☐ No
Pacemaker	☐ Yes ☐ No
Psychiatric Care	☐ Yes ☐ No
Radiation Treatment	☐ Yes ☐ No
Respiratory Disease	☐ Yes ☐ No
Rheumatic Fever	☐ Yes ☐ No
Scarlet Fever	☐ Yes ☐ No
Shortness of Breath	☐ Yes ☐ No
Sinus Trouble	☐ Yes ☐ No
Skin Rash	☐ Yes ☐ No
Stroke	☐ Yes ☐ No
Swollen Neck Glands	☐ Yes ☐ No
Swelling of Feet or Ankles	☐ Yes ☐ No
Thyroid Problems	☐ Yes ☐ No
Tobacco Habit	☐ Yes ☐ No
Tonsillitis	☐ Yes ☐ No
Tuberculosis/TB	☐ Yes ☐ No
Ulcer	☐ Yes ☐ No
Osteoporosis	☐ Yes ☐ No

Medications

List medications you are currently taking:

____

____

_

Pharmacy Name______________Phone____________

Allergies

- ☐ Aspirin
- ☐ Barbiturates (Sleeping Pills)
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other ______________

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Emergency Information

Name of nearest relative not living with you ______________________________Phone

____

Future Updates: Signature ________________ Date __________ Signature ______________ Date__________