Advanced Smile Care 22100 W. Outer Dr. Dearborn, MI 313-563-5855

Welcome

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely so we can better care for you

About You

Today's Date________________ Last Name____________________ First Name__________________________ M__________
Prefers to be called____ Mr. Mrs. Ms Dr.
Male Female SS#_______________________ Date of Birth_____________________ Present Age____________
Street Address____ Apt#_____________
City____ State___________________________ Zip_______________
Home Phone________________________ Cell Phone _________________________ Work Phone_________________
Email Address____
Marital Status_________________________ Other family members seen by us:_____________________________
Whom may we thank for referring you?____
Where is the best place, and when is the best time to reach you?_____________________________________
Previous/Present Dentist____ Date of Last Visit__________________
Employer____________________________________ Occupation_________________________ How long there?__________
Employer Address____

Insurance

Primary Insurance Information
Medical Coverage? Yes No Dental Coverage? Yes No Orthodontic Coverage? Yes No
InsuranceCompany Name____ Phone_______________________________
Insurance Company Address____
Insured's Name______________________________ SS#_________________________ Birthdate____________________
Patient's Relationshp__________________________________ Group # (Plan, Local, Policy)______________________
Insured's Employer_____________________________________ Employer's Address_______________________________
Secondary Insurance Information
Medical Coverage? Yes No Dental Coverage? Yes No Orthodontic Coverage? Yes No
InsuranceCompany Name____ Phone_______________________________
Insurance Company Address____
Insured's Name______________________________ SS#_________________________ Birthdate____________________
Patient's Relationshp__________________________________ Group # (Plan, Local,Policy#)______________________
Insured's Employer_____________________________________ Employer's Address_______________________________

Your Spouse

Name of Spouse____ Birthdate___________________
SS#______________________ Work Phone_____________________ Ext__________ Driver's License#_____________
Employer____________________________________ Occupation_________________________ How long there?__________
Employer Address____
Where is the best place, and when is the best time to reach you?_____________________________________
Whom may we thank for referring you?____

22100 W. Outer Drive, Dearborn, MI 48124

History

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions, at any time, please ask us. We are happy to help. Our office is committed to exceeding the standards of infection control mandaed by OSHA, the CDC, and the ADA.

Medical

In the event of an emergency, is there someone, who lives by you, whom we should contact?
Name_______________
Relation_______________ Home#_______________ Work#_______________
Are you currently under the care of a pysician? No Yes
Please explain_______________
Your current physical health is Good Fair Poor Do you have a personal physician? No Yes
Pysician's Name_______________Phone #_______________
Date of last visit_______________ Are you taking any prescription/over-the-counter drugs? No Yes
Please list each one:_______________
Please check any of the following diseases or medical problems which you have had:

- Anemia/Radiation Treatment
- Artificial Bones/Joints
- Artificial Valves
- Asthma/Arthritis
- Blood Transfusion
- Cancer/Chemotherapy
- Congenital Heart Defect
- Diabetes/Tuberculosis (TB)
- Difficulty Breathing
- Drug/Alcohol Abuse
- Emphysema/Gluacoma
- Epilepsy/Seizures/Fainting Spells
- Fever Blisters
- Heart Attack/Stroke
- Heart Murmur
- Heart Surgery/Pacemaker
- Hemophilia/ Abnormal Bleeding
- Hepatitis
- High/Low Blood Pressure
- HIV Positive/AIDS
- Hospitalized For Any Reason
- Kidney Problems
- Mitral Valve Prolapse
- Psychiatric Problems
- Rheumatic Fever
- Severe/Frequent Headaches
- Shingles
- Sinus Problems
- Ulcers/Colitis
- Venereal Disase

Please list any serious medical conditions you have ever had:_______________
Please check any of the following drugs that you are allergic to:
Aspirin Codeine Dental Anesthetics Erythromycin Latex Penicilin Tetracycline Other
Please list any other drugs you are allergic to:_______________
Women: Are you taking birth control pills? Yes No Are you Pregnant? Yes No Week#_______________
Are you nursing? Yes No

Dental

	YES	NO
1. Why have you come to the dentist today? _______________ _______________		
2. Are you currently in pain?............		
3. Are your teeth sensitive to heat or cold?............		
4. Have you ever had a serious/difficult problem associated with dental work?............		
5. Do you now or have you ever experienced pain in your jaw joint (TMJ/TMD)?............		
6. Would you rate your current dental health as good?............		
7. Would you rate your current dental health as fair?............		
8. Would you rate your current dental health as poor?............		
9. Do you like your smile?............		
10. Do your gums ever bleed?............		
11. Have you ever had periodontal disease?............		
12. How many times a week do you floss?_______________		
13. How many times a day do you brush?_______________		
Toothbrush bristles: hard, medium or soft?_______________		

I understand that the information I have given today is correct to the bes of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform the office of any changes in my medical status. I authorize the dental staff to preform, with my informed consent, any necessary dental services I may need during diagnosis and treatment.

Signature_______________ Date_______________

Payment is due at the time of treatment unless prior arrangemens have been made.

22100 W. Outer Drive, Dearborn, MI 48124

Child

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We srive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

About Your Child

Today's Date________________ Last Name______________________ First Name___________________________ M_________
Prefers to be called____ Male Female
SS#_______________________ Date of Birth___________________ Present Age_________ Home Phone_________________
Street Address____ Apt#______________
City____ State__________________________ Zip_____________________
Special Interests or Hobbies____
Whom may we thank for referring you?____

About You

Name____ SS#_____________________________
Relationship to Child______________________________________ Occupation___________________________
Employer____ Work Phone______________________________ Ext_________
Home Address (if different from child's)____
Home Phone(if different from child's)___________________________________ Cell Phone ______________________
Email Address____

Insurance

Primary Insurance Information
Medical Coverage? Yes No Dental Coverage? Yes No Orthodontic Coverage? Yes No
InsuranceCompany Name____ Phone______________________________
Insurance Company Address____
Insured's Name_____________________________ SS#_________________________ Birthdate______________________
Patient's Relationshp__________________________________ Group # (Plan, Local, Policy)____________________________
Insured's Employer_____________________________________ Employer's Address_________________________________
Secondary Insurance Information
Medical Coverage? Yes No Dental Coverage? Yes No Orthodontic Coverage? Yes No
InsuranceCompany Name____ Phone______________________________
Insurance Company Address____
Insured's Name_____________________________ SS#_________________________ Birthdate______________________
Patient's Relationshp__________________________________ Group # (Plan, Local,Policy#)_____________________________
Insured's Employer_____________________________________ Employer's Address_________________________________

22100 W. Outer Drive, Dearborn, MI 48124

Child's History

Thank you for filling out this form completely. It will enable us to your child the best dental care possible.
If you or your child have any questions, please feel free to ask us at any time.

Medical

In the event of an emergency, whom should we contact?

Name____

Relation____________________ Home#____________________ Work#____________________

Please check any of the following medical conditions or problems which your child has had:

Heart Murmur
Heart Problems of Any Kind
Convulsions/Epilepsy
Cancer
Diabetes

Rheumatic Fever
HIV/AIDS
Hemophilia
Bleeding Problems of Any Kind
Hearing Impairment

Hyperactive
Any Operations________________
____
Any Hospital Stays________________
____

Please list if there any medical conditions or problems relating to your child that need further explanation:

____

____

Dental

YES NO

1. Has your child been to the dentist before?..
If yess, approximate date of last visit________________________
2. are there any dental problems you are aware of at present?
If yes, explain________________________
3. Does your child brush daily?..
4. How would you rate your child's oral health?
Good, Fair, or Poor:________________________
5. Is your child under the care of a physician?..
6. Child's Physician:________________________

YES NO

7. Physician Phone________________________
8. Approximate date of last visit________________________
9. Please rate your child's mental health.
Good, Fair, or Poor:________________________
10. Is your chld allergic to any drugs?..
If yes, please list________________________
11. Is your child taking any prescription drugs?..
If yes, please list________________________
12. Does child need to be premedicated before dental treatment?

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform the office of any changes in my child's medical status. I also authorize the dental staff to preform the necessary dental services that my child may need.

Signature of Guardian________________________________ Date________________

The Parent or Guardian who accompanies the child is responsible for payment at the time of service unless prior arrangements have been approved.