**The best you are starts with a Smile.**

# Welcome

*Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us- we will be happy to help.*

JOHN O. LEITNER, D.D.S., PLC

Professional Arts Building
575 Robbins Road
Grand Haven, MI 49417
**(616) 842-2850**

**PATIENT INFORMATION (Confidential):** Date: _____

Name: _____ Birthdate: _____ Home Phone: _____

Residence Address _____
Number Street City State Zip

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If student, name of school/college _____ Location: _____

Patient's or parent's employer: _____ work phone: _____

Business Address: _____

Spouse or parent's name: _____ work phone: _____

Employer: _____

Whom may we thank for referring you? _____

Person to contact in case of emergency: _____

**RESPONSIBLE PARTY:**

Name of person responsible for this account: _____ Relationship to patient: _____

Address: _____ Home phone: _____

Birthdate: _____ SS#: _____

Employer: _____ Work phone: _____

Is this person currently a patient in our office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ Master Card ☐ Discover ☐ Amex

☐ I wish to discuss the office's payment policy ☐ Care Credit

**INSURANCE INFORMATION:**

Name of Insured: _____ Relationship to patient: _____

Birthdate: _____ S.S. #: _____ Date employed: _____

Name of employer: _____ Union or Local #: _____ Work phone: _____

Address of employer: _____

Insurance Company: _____ Group #: _____ Policy/ID #: _____

Ins. Co. Address _____

Have you used your dental insurance elsewhere this year? ☐ Yes ☐ No

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DO YOU HAVE ANY ADDITIONAL INSURANCE? YES NO IF YES, COMPLETE THE FOLLOWING:

Name of insured: _____ Relationship to patient: _____

Birthdate: _____ SS#: _____ Date employed: _____

Name of employer: _____ Union or local #: _____ Work phone: _____

Address of employer: _____

Insurance company: _____ Group #: _____ Policy/ID #: _____

Ins. Co. Address: _____

## PATIENT HEALTH HISTORY

Family Physician: _____ Specialty: _____

Address: _____

Additional Physician: _____

Address: _____

Date of Last Complete Medical Examination: _____

Pharmacy: _____

Are You Taking Any Medication Now? Please list:

Taking _____ for _____ Taking _____ for _____

Taking _____ for _____ Taking _____ for _____

Taking _____ for _____ Taking _____ for _____

Taking _____ for _____ Taking _____ for _____

Indicate which of the following you have had, or have at present.

| | Yes | No | Date | | Yes | No | Date |
|---|---|---|---|---|---|---|---|
| Heart disease | | | | Tuberculosis/lung disease | | | |
| Rheumatic fever | | | | Diabetes | | | |
| Artificial heart valves | | | | Family members? | | | |
| Artificial joints | | | | Asthma or hay fever | | | |
| Abnormal blood pressure | | | | Sinus trouble | | | |
| Heart murmur | | | | Hepatitis | | | |
| Heart attack | | | | HIV virus (AIDS, ARC) | | | |
| Cardiac Pacemaker | | | | Serious accident | | | |
| Mitral valve prolapse | | | | Arthritis | | | |
| Epilepsy/Convulsions | | | | Stroke | | | |
| Anemia | | | | Glaucoma | | | |
| Cold sores/fever blisters | | | | Liver disease | | | |
| Cancer | | | | Kidney diseases | | | |
| thyroid problem | | | | Recent weight loss | | | |
| Angina (chest pains) | | | | Emphysema | | | |
| Respiratory problems | | | | Radiation Therapy | | | |

Other disease/condition, explain: _____

_____

_____

**Please turn page**

**MEDICAL HISTORY (Continued)**

Are you allergic to: Penicillin_____ Codeine_____ Local injected anesthetics_____
Metals (nickel, mercury, gold, silver)_____ Latex rubber_____
Other medications: _____
Are you subject to prolonged bleeding?_____
Are you subject to fainting spells?_____
Do you use any tobacco products?_____
Do you use any alcohol products? _____

WOMEN:
Are you pregnant?_____ Nursing?_____
Are you taking birth control pills?_____

**DENTAL HISTORY**

Previous Dentist: _____
Address: _____ Phone: _____
Other
Dentist: _____ Speciality: _____
Address: _____ Phone: _____
Last full mouth x-ray:_____ Last complete Dental Exam: _____
What is your immediate dental concern:_____

Have you ever had any serious problems associated with previous dental treatment?
☐Yes ☐ No Prolonged bleeding? ☐ Yes ☐ No If so, explain:_____

How often do you brush your teeth?_____
What texture brush do you use? Soft Medium Hard
How often do you floss?_____

| | | |
|---|---|---|
| Are you aware of the Rotadent brush? | Yes | No |
| Do your gums bleed while brushing or flossing? | Yes | No |
| Do your gums feel tender or swollen? | Yes | No |
| Have you ever had orthodontic treatment (braces)? | Yes | No |
| Do you avoid brushing any parts of your mouth because of pain? | Yes | No |

If yes, what part?_____

Do you feel twinges of pain when your teeth come in contact with:

| | | |
|---|---|---|
| a) Hot foods or liquids (soups, coffee, tea, etc) | Yes | No |
| b) Cold foods or liquids (ice cream, cold fruit, etc.) | Yes | No |
| c) Sweets (candy,fruit, sweet desserts, etc.) | Yes | No |
| d) Sours (lemons, limes, grapefruit, etc.) | Yes | No |
| Do you chew on only one side of your mouth? | Yes | No |

If so, explain:_____

| | | |
|---|---|---|
| Do you clench or grind your jaws while sleeping or during the day? | Yes | No |

**Please turn page**

**DENTAL HISTORY (Continued)**

Have you ever experienced any of the following problems in your jaw?

- Clicking . . . . . Yes No
- Pain (joint, ear, side of face) . . . . . Yes No
- Difficulty in opening or closing . . . . . Yes No
- Difficulty in chewing . . . . . Yes No
- A tired feeling . . . . . Yes No

Do you have any of the following aches? Headache Neck Shoulder Jaw Ear

Are you aware of any lumps or sores that have appeared in your mouth? . . . . . Yes No

Do you wear dentures or partial dentures? . . . . . Yes No

- If yes, date of last placement_____

Do you usually have many cavities? . . . . . Yes No

Do you lose fillings or break fillings? . . . . . Yes No

Do you gag easily? . . . . . Yes No

Are you usually nervous during dental visits? . . . . . Yes No

Do you prefer local anesthetic during dental visits? . . . . . Yes No

Are you familiar with the term “preventive dentistry?” . . . . . Yes No

Do you like your smile? . . . . . Yes No

Would you like to keep the teeth you have all of your life? . . . . . Yes No

Please add anything you feel is important**:** _____

## AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature:_____ Date:_____

**Doctor’s Notes:**