

Harbor Lights Dental Care

575 Robbins Road, Suite B. Grand Haven, MI 49417

Thank you for selecting our dental healthcare team!
With our Microscopic Enhanced Dentistry we are focused on
providing our patients with the best possible care!
To help us meet all your dental healthcare needs, please fill out this
form completely in ink. If you have questions or need assistance, please ask
us-we are always happy to help!

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 _____ Email: _____

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:

Relationship

Name of person responsible for this account: _____ 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:

Relationship

Name of Insured: _____ 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

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	_____	_____	_____
sores/fever blisters	_____	_____	_____	Liver disease	_____	_____	_____
Kidney diseases	_____	_____	_____	thyroid problem	_____	_____	_____
weight loss	_____	_____	_____	Angina (chest pains)	_____	_____	_____
Respiratory problems	_____	_____	_____	Radiation Therapy	_____	_____	_____
							Cold
							Cancer
							Recent
							Emphysema

Other disease/condition, explain: _____

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

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:
