Patient Information					
First Name:		Last Name:			Middle Initial:
Preferred Name:		Salutation: ❑ Miss ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr.			
Address:			City, State, Zip:		
Home Phone:		Cell Phone:		Work Phone:	
Sex: ❑ Male ❑ Female		Marital Status: ❑ Divorced ❑ Married ❑ Separated ❑ Single ❑ Widowed			
DOB:	SSN:		Email:		
Employment Status: ❑ FT ❑ PT ❑ Retired ❑ N/A			Pre-Med Necessary:		
Pharmacy:				Pharmacy Phone:	
Emergency Contact:			Relationship:		Phone:
How did you find us:	❑ Facebook ❑ Google ❑ Healthgrades ❑ Instagram ❑ Insurance ❑ Muskegon Chamber of Com. ❑ Patient ❑ Smile Michigan ❑ Twitter ❑ Website ❑ Welcome Wagon ❑ Yellow Pages ❑ Yelp				

Responsible Party *(If someone other than the patient)*			
First Name:	Last Name:		Middle Initial:
Address:		City, State, Zip:	
Home Phone:	Cell Phone:		Work Phone:
DOB:	SSN:	Relationship:	

Primary Insurance	
Policy Holder:	
Relationship: ❑ Self ❑ Spouse ❑ Child ❑ Other	
SSN:	DOB:
Employer:	
Ins Company:	
ID#:	Gr#:

Secondary Insurance	
Policy Holder:	
Relationship: ❑ Self ❑ Spouse ❑ Child ❑ Other	
SSN:	DOB:
Employer:	
Ins Company:	
ID#:	Gr#:

Dental History					
Do your gums bleed when you brush or floss?	**Y**	**N**	Has anyone ever told you that you snore?	**Y**	**N**
Are your teeth sensitive to cold, hot, sweets or pressure?	**Y**	**N**	Do you suffer from daytime sleepiness?	**Y**	**N**
Do you have dry mouth?	**Y**	**N**	Do you wear a CPAP?	**Y**	**N**
Have you had periodontal treatment (gums)?	**Y**	**N**	Date of last exam & cleaning:		
Have you had orthodontic treatment (braces)?	**Y**	**N**	Date of last x-rays:		
Have you had problems with previous dental treatment?	**Y**	**N**	Do you like your smile?		
Are you currently experiencing pain or discomfort?	**Y**	**N**	Previous dentist:		
Do you have clicking, popping or discomfort in the jaw?	**Y**	**N**	What is the reason for your visit today?		
Do you clench or grind your teeth?	**Y**	**N**			
Do you have sores or ulcers in your mouth?	**Y**	**N**			
Have you had any head, neck or jaw injuries?	**Y**	**N**			