Dr. Ronald Olszewski D.D.S
6640 28th Street SE, Grand Rapids, MI 49546

Patient Information Date _______________

Patient's Name ____ M___ F___

Address ___________________________________ City _______________ Zip _____________ State ___

Cell Phone ______________________ Alternate Phone _____________________

Birthdate _________________ Social Security #___________________________

Whom may we thank for referring you to our office? ______________________________

Responsible Party/Primary Insurance Information

Name ____________________________Birthdate ____________________Relation to patient ________

Address (if different from patient)____

Social Security #_______________________ Cell Phone ____________________

Employer _________________________ Insurance Company _________________________

Policy #___________________ Group #_______________ Is there secondary Insurance ___________

Emergency Contact

Name ______________________________ Relationship ________________________

Address _____________________________Phone ________________________________

Dental Health

Reasons for today's visit? _______________________________

Have you had any serious trouble with previous dental work? If yes, please explain

____

When was your last dental visit? _______________________Previous dentist name________________

How often do you brush? __________________ How often do you floss? ___________________

	Y	N
Do you snore?	___	___
Do you feel like you have bad breath?	___	___
Do you have sensitivity to hot/cold/chewing?	___	___
Do you currently use any tobacco products?		

Most recent blood pressure ___________

Medical History

Are you taking any prescription or over the counter prescriptions? ________

Medication: Dosage: How often taken: Reason for prescription:

1.____

2.____

3.____

4.____

Name of Physician ____________________ Phone number____________________

Are you currently under care of a physician or receiving ongoing medical care? ____________

Are you currently pregnant? ____ ____

Are you currently breastfeeding? ____ ____

Do you have any artificial joints, heart valves, implants, or prosthesis? ____ ____

Have you ever been told you need to pre-medicate for a dental procedure? ____ ____

Please list all allergies (please write none if you have no allergies)

____

Please check any pertinent health history below

	Yes	No		Yes	No
Heart Disease	____	____	Asthma	____	____
Heart murmur	____	____	Hay Fever/Hives	____	____
Rheumatic Fever	____	____	Sinus Trouble	____	____
Abnormal Blood pressure	____	____	Hepatitis A, B, C	____	____
Ulcers	____	____	Arthritis	____	____
TB/lung disease	____	____	Chest Pain	____	____
Diabetes- Type 1	____	____	AIDS or HIV	____	____
Diabetes- Type 2	____	____	Glaucoma	____	____
Epilepsy	____	____	Seizures	____	____
Anemia	____	____	Parkinson	____	____
Cold Sores/herpes	____	____	Dementia	____	____
Hemophilia	____	____	Autoimmune Disease	____	____
Stoke	____	____	Bleeding problems	____	____
Swollen feet	____	____	Chemical Dependency	____	____
Nervous problems	____	____	Radiation treatment	____	____
Lupus	____	____	Sjogren's Syndrome	____	____
Head injury	____	____	Any other disease not listed:		
Jaundice	____	____			
Liver disease	____	____	If yes, please list ____________________		

I have completed this form fully and completely to the best of my knowledge. If I ever have a change in my health or medications, I will notify my provider immediately. I herby give consent to treatment for myself or the named individual on this form

Signature ________________________________ Date ______________