

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 _____ Email _____

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/nicotine products?	___	___
Do you currently use any products containing THC?	___	___

Medical History

Name of Physician _____ Phone number _____

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

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

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

1. _____
2. _____
3. _____
4. _____

Please list all previous surgeries:

	Y	N
Are you currently pregnant?	_____	_____
Are you currently taking birth control?	_____	_____
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 TO MEDICATIONS (LIST NONE IF YOU HAVE NONE)

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	_____	_____
Stroke	_____	_____	Bleeding problems	_____	_____
Swollen feet	_____	_____	Chemical Dependency	_____	_____
Nervous problems	_____	_____	Radiation treatment	_____	_____
Lupus	_____	_____	Sjogren's Syndrome	_____	_____
Head injury	_____	_____			
Latex Allergy	_____	_____	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 hereby give consent to treatment for myself or the named individual on this form

Signature _____ Date _____

Updated initials and date: _____