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_____

Home Phone_____Work Phone_____

Birthdate_____ SS#_____

If patient is a minor, give parent's or guardian's name_____

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

Responsible Party / Primary Insurance Information

Name_____

Address (if different from patient)_____

Home phone_____ Work phone_____

SS#_____Birthdate_____Relationship to patient_____

Employer_____Occupation_____Ins. Company_____

Insurance Company Address_____Group #_____

Secondary Insurance Information

Name_____

Address (if different from patient)_____

Home Phone_____Work Phone_____

SS#_____Birthdate_____Relationship to patient_____

Employer_____Occupation_____Ins. Company_____

Insurance Company Address_____Group #_____

Emergency Information

Name of nearest relative_____Relationship_____

Address_____Phone_____

Medical Health

General Health (please check one): Excellent_____Good_____Fair_____Poor_____ Heitht_____Weight_____

Name and address of physician_____

Last completed physical_____Are you under the care of a physician now?_____For?_____

Are you taking medication now?_____Please list_____

Women: Do you take the birth control pill?_____ Are you pregnant? _____ Nursing?_____

Have you ever had or been treated for:	Yes	No		Yes	No
Heart disease			Lupus		
Heart murmur or mitral valve prolapse.			Head injury		
Rheumatic fever			Jaundice or liver disease		
Abnormal blood pressure			Asthma		
Ulcers			Hay fever or hives		
Tuberculosis or lung disease			Sinus trouble		
Diabetes			Hepatitis A, B, non B, or C		
Epilepsy			Arthritis		
Anemia			Angina		
Cold sores or herpes			AIDS or HIV		
Hemophilia or other blood diseases			Joint or heart valve replacement		
Stroke			Glaucoma		
Swollen feet or ankles			Chemical dependency		
Nervous problems			Radiation treatment		
Latex Allergy					

	Yes	No
Have you lost or gained 10 lbs. in the last 6 months?	_____	_____
Do you smoke?	_____	_____
Do you have excessive thirst or urination?	_____	_____
Have you ever had plastic surgery of any kind?	_____	_____

Most recent blood pressure?_____

Are you allergic to any medications?

Codeine_____Penicillin_____Local anesthetics_____Other_____None_____

Dental Health

Reasons for today's visit?_____

When was your last dental visit?_____Why did you leave that dentist?_____

How often do you brush?_____How often do you floss?_____

Do you like the color/appearance of your teeth?	_____
Do you breath through your mouth?	_____
Do you snore?	_____
Are you often tired during the day?	_____
Do you feel you have bad breath?	_____
Do your gums bleed when you brush or floss?	_____
Do you clench or grind your teeth at any time?	_____
Do you chew on one side of your mouth?	_____
Do you have frequent headaches?	_____
Does your jaw click or pop with chewing?	_____
Do you have sensitivity to.....?	_____Hot_____Cold_____Chewing

I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I understand that my dental insurance is a contract between my insurance company and myself, and that I am responsible for any remaining balance not paid by this insurance company.

Signature_____Date_____

Update - Initial:_____ _____ _____ _____ _____ _____