

**PATIENT INFORMATION**

**BURTON DENTAL CENTER, P.C.  
P.O. BOX 90459  
BURTON MI 48509 (810) 744-0433**

PATIENT NAME: \_\_\_\_\_

Preferred name: \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

D.O.B. \_\_\_\_\_ S / M / D / W SS#: \_\_\_\_\_ Name of spouse \_\_\_\_\_  
Or parent

Employed by: \_\_\_\_\_ Address \_\_\_\_\_

May we contact you at work? Yes: \_\_\_\_\_ No: \_\_\_\_\_ Work Phone # \_\_\_\_\_

Person to contact in case of emergency \_\_\_\_\_ Phone \_\_\_\_\_  
(Outside the home)

Address \_\_\_\_\_ Relationship \_\_\_\_\_

Whom may we thank for referring you to our office: \_\_\_\_\_

PRIMARY INSURANCE		
<b>SUBSCRIBER:</b>		<b>D.O.B.:</b>
<b>INSURANCE COMPANY:</b>	<b>SS#</b>	<b>H / S</b>
<b>EMPLOYER NAME:</b>	<b>GROUP #:</b>	
<b>BENEFIT REP AT EMPLOYER:</b>	<b>PHONE #:</b>	

SECONDARY INSURANCE		
<b>SUBSCRIBER:</b>		<b>D.O.B.:</b>
<b>INSURANCE COMPANY:</b>	<b>SS#</b>	<b>H / S</b>
<b>EMPLOYER NAME:</b>	<b>GROUP #:</b>	
<b>BENEFIT REP AT EMPLOYER:</b>	<b>PHONE #:</b>	

I hereby authorize payment to go directly to **BURTON DENTAL CENTER, P.C.** from my insurance company for services rendered. I understand that I am responsible for all costs of treatment, whether my insurance company pays or not. I am responsible for knowing what benefits my insurance company covers and will settle any dispute with them myself. **All payments are due at time of service.**

I understand that if I need to cancel an appointment I must call the office by **12 noon** the previous business day to avoid a **\$55.00** cancellation charge.

I understand that if a check is returned for nonsufficient funds that I will be charged a fee of **\$35.00**, and all future payments must be made either with cash or a money order.

I authorize the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.

**I understand that an adult must accompany any minor child to all appointments. I also understand that in a divorce situation the adult accompanying the minor is responsible for payment at time of service.**

The information I have given on this form is correct to the best of my knowledge.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
(Signature of parent if child)

I/We authorize **BURTON DENTAL CENTER, P.C.** to obtain credit history information through **Flint Credit Bureau.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Witness: \_\_\_\_\_

### HEALTH HISTORY

In order to better serve you and protect your health, we need to know your dental and medical history. Your history will be carefully reviewed and used to aid us in giving you the highest dental care.

Physicians Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Date of last physical examination: \_\_\_\_\_

Have you been hospitalized within the past two years? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you been under the care of a physician in the past two years? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you allergic to penicillin, aspirin, codeine, local anesthetics, latex, metals, or any other medications? \_\_\_\_\_

Is there anything which gives you a rash, itching, swelling of the hands, feet or eyes? \_\_\_\_\_

Have you ever had excessive bleeding requiring special treatment? Yes \_\_\_\_\_ No \_\_\_\_\_

Circle (yes or no to the following)

YES NO 1. Are you having pain or discomfort at this time? \_\_\_\_\_

YES NO 2. Do you feel nervous about having dental treatment? \_\_\_\_\_

YES NO 3. Have you ever had a bad experience in the dental office? \_\_\_\_\_

YES NO 4. Is there anything that you dislike about your smile? \_\_\_\_\_

YES NO 5. Have you ever had any instructions in oral hygiene? \_\_\_\_\_

YES NO 6. Are there now any growths or sores in or around your mouth? \_\_\_\_\_

YES NO 7. Do you have trouble chewing? \_\_\_\_\_

YES NO 8. Does food catch between your teeth? \_\_\_\_\_

YES NO 9. Do you have pain in or near your ears? \_\_\_\_\_

YES NO 10. Do you habitually clench or grind your teeth during the day or night? \_\_\_\_\_

YES NO 11. Have you ever been told that you have gum problems? \_\_\_\_\_

YES NO 12. Is there anything related to your medical or dental history that you have not indicated above? \_\_\_\_\_

If yes, explain? \_\_\_\_\_

Please list all current medications: \_\_\_\_\_

Circle any of the following you have had or presently have:

\* Antibiotic premedication may be required prior to your appointment.

Heart Failure	Kidney Disorders	HIV Positive, ARC, AIDS
Heart Disease/Attack	Ulcers	Alcoholism
Angina Pectoris	Use of Tobacco Products	Drug Addiction
High Blood Pressure	Emphysema	Glaucoma
*Mitral Valve Prolapse	Tuberculosis (TB)	Cortisone Medicine
*Heart Murmur	Asthma	Hepatitis ( Type: _____ )
*Rheumatic Fever	Sinus Problems	Liver Disease
Congenital Heart Lesions	Hay Fever	Jaundice
Heart Pace Maker _____	Allergies or Hives	Blood Transfusion
Heart Surgery _____	Diabetes	Bleeding Disorder
Cancer (Type: _____)	Radiation Treatment	Bruise Easily
Anemia	Chemotherapy	Cold Sores
Stroke	Arthritis	Herpes
Epilepsy	Fainting or Dizzy Spells	*Any type of implant _____
*Artificial Hip, Knee or Joint	Sickle Cell Disease	*Any type of Transplant _____

**WOMEN:**

Are you pregnant? Yes/No Are you nursing? Yes/No Are you taking birth control pills? Yes/No

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I have reviewed my medical history and the above information (including changes) is accurate.

Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Date: \_\_\_\_\_ Initials: \_\_\_\_\_

Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Date: \_\_\_\_\_ Initials: \_\_\_\_\_