Thomas Stout D.D.S. ~ Daniel B.Gordon D.D.S. ~ Steven M. Prince D.D.S

12723 N. Bellwood – Suite 30, Holland, MI 49423

Welcome! We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, please don't hesitate to ask. We'll be glad to help you.

PATIENT INFORMATION

Name____Nick Name____________________ Soc. Sec. #_______________
Last First Initial

Address____
Street Apt# City State Zip

Phone____ Email_____________________________
Home Work Cell

Sex ☐ Male ☐ Female Age ______Date of Birth______________ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Name of Employer____ Occupation____________________________

Business Address____
Street Ste# City State Zip

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

INSURANCE INFORMATION

Primary Insurance
(If no insurance complete for person responsible for account)

Last Name First Initial

Street Apt# City State Zip

Home Phone Work Cell

Birthday (Mo/Day/Year) Relationship to patient

Employer Employer Phone

Street Address City State Zip

Insurance Co. Soc. Sec. #

Contract # Group # Subscriber #

Secondary Insurance
(If no additional insurance, leave blank)

Last Name First Initial

Street Apt# City State Zip

Home Phone Work Cell

Birthday (Mo/Day/Year) Relationship to patient

Employer Employer Phone

Street Address City State Zip

Insurance Co. Soc. Sec. #

Contract # Group # Subscriber #

PATIENT CONTACT IN CASE OF EMERGENCY

First Name Last Name

Home Phone Work Phone Cell

Has any member of your family ever been treated in our office?
☐ Yes ☐ No ______________________________________

AUTHORIZATION

I hereby authorize payment directly to Stout, Gordon and Prince Family Dentistry of all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. **I understand that I am financially responsible for all costs of dental treatment whether or not paid by insurance. I understand that payment is due in full at time of treatment, unless prior arrangements have been approved.**

I hereby authorize the office of Stout, Gordon and Prince Family Dentistry to administer such medications and perform such diagnostic, photographic, and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories page are correct to the best of my knowledge. I authorize the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

Signature____Date_____________________

Please complete both sides

DENTAL HISTORY

Primary reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Other: ____________________

On a scale of 0 (no pain) to 10 (extreme pain) how would you rate your dental pain today? ____________________

Check (√) yes or no whether you have had any of the following:

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Bleeding Gums	☐	☐	Loose teeth or broken fillings	☐	☐	Clicking or popping jaw	☐	☐	Sensitivity to hot
☐	☐	Bad breath	☐	☐	Food catch between teeth	☐	☐	Sores or growths in mouth	☐	☐	Sensitivity to cold
☐	☐	Treatment for gum disease	☐	☐	Grinding or clenching teeth	☐	☐	Sensitivity when biting	☐	☐	Sensitivity to sweets

How do you feel about the appearance of your teeth? ____________________

Do you wish your teeth were whiter? ______________ Do you wish your teeth were straighter? ______________

How often do you brush your teeth? ______________ How often do you floss? ______________

Do you think you have active decay or gum disease? ______________ Do you want to keep your remaining teeth? ______________

Other information that you want to tell us about your teeth or past treatment____________________

Previous Dentist______________ Address______________

Dentist's Phone______________ Date of last dental appointment______________ Date of last xrays______________

MEDICAL HISTORY

Physician's Name______________ Address______________

Phone______________ Date of last visit______________ Have you had any serious illnesses, injuries or operations? ☐ Yes ☐ No

If yes, please describe____________________

Are you currently under physician's care? ☐ Yes ☐ No If yes, please describe____________________

Do you have any material allergies (examples: latex, metals, jewelry, chemicals, etc)? ☐ Yes ☐ No If yes, please list all______________

____

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, please list all ______________

____

Have you ever taken any Bisphosphonate medications (examples: Aredia, Zometa, Fosamax, Actonel, Boniva)? ☐ Yes ☐ No ______________

Women: Are you pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

DO YOU HAVE ANY DRUG ALLERGIES? ☐ Yes ☐ No If yes, please list____________________

DO YOU REQUIRE A PRE-MED BEFORE DENTAL WORK? ☐ Yes ☐ No

Check (√) yes or no whether you have had any of the following:

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	AIDS/HIV positive	☐	☐	Chemical dependency	☐	☐	Hay Fever	☐	☐	Other heart problems
☐	☐	Alcoholism	☐	☐	Chemotherapy	☐	☐	Headaches	☐	☐	Pacemaker or defibrillator
☐	☐	Allergies/Hives	☐	☐	Chronic cough	☐	☐	Heart disease/heart attack	☐	☐	Persistent diarrhea
☐	☐	Anaphylaxis	☐	☐	Congential heart defect	☐	☐	Heart murmur	☐	☐	Psychiatric treatment
☐	☐	Anemia	☐	☐	Cortisone medication	☐	☐	Heart surgery or transplant	☐	☐	Radiation treatment
☐	☐	Aneurysm	☐	☐	Cough up blood	☐	☐	Hemophilia/Bleeding disorder	☐	☐	Renal Dialysis
☐	☐	Angina pectoris/chest pain	☐	☐	Diabetes	☐	☐	Hepatitis (Type______)	☐	☐	Rheumatic fever
☐	☐	Arrhythmias	☐	☐	Discolored areas in mouth	☐	☐	High blood pressure	☐	☐	Sickle cell disease
☐	☐	Arthritis	☐	☐	Emphysema	☐	☐	Kidney disorders	☐	☐	Sinus trouble
☐	☐	Artificial heart valve	☐	☐	Epilepsy or seizures	☐	☐	Leukemia	☐	☐	Skin rash
☐	☐	Artificial hip, knee, other joint	☐	☐	Fainting or dizzy spells	☐	☐	Liver disease/cirrhosis	☐	☐	Stomach/Intestinal ulcers
☐	☐	Asthma	☐	☐	Fever blisters; cold sores	☐	☐	Mitro valve prolapse	☐	☐	Stroke
☐	☐	Back problems	☐	☐	Food allergies	☐	☐	Mouth ulcers/canker sores	☐	☐	Thyroid disease
☐	☐	Blood transfusion	☐	☐	Frequent Urination	☐	☐	Nervousness	☐	☐	Tobacco habit
☐	☐	Breathing difficulties	☐	☐	Gastritis/Colitis	☐	☐	Night sweats	☐	☐	Tuberculosis (TB)
☐	☐	Bruises easily	☐	☐	Glaucoma	☐	☐	Osteoporosis	☐	☐	Tumor or cancer

Have you had any other serious diseases, problems or conditions not listed above? ☐ Yes ☐ No Describe:______________

To the best of my knowledge, all preceding answers are correct. If I have changes in my health status or medicines, I will inform the dentist/staff at the next appointment without fail.

____________________ ______________

Patient Signature (Parent or Guardian) Date

REVIEWED BY:______________DATE__________BP__________PULSE__________

HISTORY REVIEW AND SIGNIFICANT FINDINGS:____________________

Please complete both sides

Patient Responsibility/Office Policies

Welcome to our office! We strive to make sure that we accommodate your needs to the best of our abilities, while ensuring that you fully understand our policies, treatment, and payment agreements. If at any time you have a question, or are unhappy about your treatment plan, our fees or services, please discuss it with us promptly and openly. We will gladly answer your questions courteously and to the best of our ability.

Financial
As a courtesy to you, we are happy to bill your insurance. Your coverage is between you and your insurance provider. If you dispute any payments or lack there of, you will need to discuss this with your insurance carrier. We are a provider of dental treatment, not a provider of insurance.
The office will honor the fees quoted for **90 days** upon presentation of the treatment plan.

Appointment Policy/Cancellation Policy
When scheduling your appointments, we are making a commitment to you. Please remember that we have reserved a special time for you. If you need to reschedule your appointment, our office requests as much notice as possible, preferably at last 48 hours. We certainly understand that emergencies can happen, however, excessive failed or cancelled appointments could potentially result in a $25 charge per patient, per visit, or even dismissal from the practice.
We request you check in 5 minutes prior to your appointment. We make every effort to run on time. If you are more than 10 minutes late for any appointment you may end up being rescheduled.

X-rays
The frequency of getting x-rays of your teeth often depends on your medical and dental history and current condition. Some people may need x-rays as often as every six months; others with no recent dental or gum disease and who visit their dentist regularly may get x-rays every year or two. If you are a new patient and so not have current x-rays, we will need to take x-rays as part of the initial exam, to establish a baseline record from which to compare changes that may occur over time. An x-ray liability waiver will need to be signed, if x-rays are denied when strongly recommended.

Emergencies
We will try to treat your emergency as soon as possible. If you are unable to contact us, you need to seek attention from your physician, urgent care clinics, or an emergency room.

Signature____Date___________________________
(Parent or Guardian, if patient is under age 18)

Privacy Practices

I, ____________________________, have received a copy of this office's Notice of Privacy Practices.
I understand that I may receive appointment confirmation messages (as well as reminders about pre-medicating prior to an appointment) via answering machine, voicemail, postcard, or through another member of the household.
Who may we speak to regarding your Dental Health? ____

Signature____Date_______________________

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) ___________________________________

Signature____Date___________________________
(Employee Signature)