



Sonne & Shapiro Dental P.C.
PREVENTIVE & ESTHETIC DENTISTRY

WELCOME!

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental health-care needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us—we will be happy to help.

Date: _____

1550 Kingsway Court • Trenton, MI 48183 • 734.671.8414 • Fax: 734.671.8234 • www.sonneandshapiro dental.com

PATIENT INFORMATION

Check Appropriate Box: Minor Single Married Divorced Widowed Separated

Name _____ Birthdate _____ Social Security No. _____

Spouse/Significant Other _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____ Email _____

Are you a student? Yes No School _____

Driver's License Number _____ Whom may we thank you for referring you? _____

Person to contact in case of emergency _____ Phone _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Driver's License No. _____ Birthdate _____

Employer _____ Work Phone _____

Is this person currently a patient in our Office? Yes No

INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security No. _____

Employer _____ Work Phone _____

Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group No. _____ Union or Local No. _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security No. _____ Date Employed _____

Employer _____ Work Phone _____

Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group No. _____ Union or Local No. _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

Physician _____ Office Phone _____ Date of Last Exam _____

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Are you under medical treatment now? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, for what condition? _____ | | |
| _____ | | |
| _____ | | |
| 2. Have you ever been hospitalized for any surgical operation or serious illness? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, date and reason for hospitalization? _____ | | |
| _____ | | |
| _____ | | |
| 3. Are you taking any prescription or non-prescription medications, including vitamin or herbal supplements? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, what medications are you taking? _____ | | |
| _____ | | |
| _____ | | |
| 4. Do you smoke? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, packs per day? _____ | | |
| Do you use smokeless tobacco? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you use alcohol? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you use cocaine or other drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are you wearing contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Are you allergic to or have you had any reactions to the following: | | |
| Local Anesthetics (eg. novocaine) | <input type="checkbox"/> | <input type="checkbox"/> |
| Penicillin or other Antibiotics | <input type="checkbox"/> | <input type="checkbox"/> |
| Sulfa Drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| Barbiturates | <input type="checkbox"/> | <input type="checkbox"/> |
| Sedatives | <input type="checkbox"/> | <input type="checkbox"/> |
| Iodine | <input type="checkbox"/> | <input type="checkbox"/> |
| Aspirin | <input type="checkbox"/> | <input type="checkbox"/> |
| Latex | <input type="checkbox"/> | <input type="checkbox"/> |
| Codeine or other pain medications? | <input type="checkbox"/> | <input type="checkbox"/> |
| Other _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Women Only: | | |
| a) Are you pregnant or think you may be pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Are you nursing? | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Are you taking birth control pills? | <input type="checkbox"/> | <input type="checkbox"/> |

- | | Yes | No |
|---|--------------------------|--------------------------|
| 10. Do you have or have you had any of the following? | | |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| Damaged Heart Valves | <input type="checkbox"/> | <input type="checkbox"/> |
| Congenital Heart Defects | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic Heart Disease or Rheumatic Fever .. | <input type="checkbox"/> | <input type="checkbox"/> |
| Swollen Ankles | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting/Seizures | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| Low Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy/Convulsions | <input type="checkbox"/> | <input type="checkbox"/> |
| Leukemia | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney Diseases | <input type="checkbox"/> | <input type="checkbox"/> |
| Aids or HIV Infection | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid Problem | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Cardiac Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> |
| Angina | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequently Tired | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> | <input type="checkbox"/> |
| Emphysema | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| Joint Replacement or Implant | <input type="checkbox"/> | <input type="checkbox"/> |
| Hepatitis/Jaundice | <input type="checkbox"/> | <input type="checkbox"/> |
| Sexually Transmitted Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Stomach Troubles/Ulcers | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest Pains | <input type="checkbox"/> | <input type="checkbox"/> |
| Easily Winded | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| Hay Fever/Allergies | <input type="checkbox"/> | <input type="checkbox"/> |
| Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Radiation Therapy | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> |
| Recent Weight Loss | <input type="checkbox"/> | <input type="checkbox"/> |
| Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Trouble | <input type="checkbox"/> | <input type="checkbox"/> |
| Respiratory Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Gastric Reflux | <input type="checkbox"/> | <input type="checkbox"/> |
| Eating Disorders | <input type="checkbox"/> | <input type="checkbox"/> |
| Bleeding Disorders | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent Bruising | <input type="checkbox"/> | <input type="checkbox"/> |
| Psoriasis or other skin conditions | <input type="checkbox"/> | <input type="checkbox"/> |

11. Do you have any conditions or problems not listed above?

Name of Previous Dentist _____

Reason and Date of Last Dentist Visit _____

Reason for This Appointment _____

- | | Yes | No | | Yes | No |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Do your gums bleed while brushing or flossing? | <input type="checkbox"/> | <input type="checkbox"/> | 8. Do you have frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are your teeth sensitive to hot or cold liquids/foods? | <input type="checkbox"/> | <input type="checkbox"/> | 9. Do you clench or grind your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are your teeth sensitive to sweet or sour liquids/foods? | <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you have any biting or chewing habits? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you feel pain to any of your teeth? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Fingernails, pen, or pencil | | |
| 5. Do you have any sores or lumps in or near your mouth? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Cheek, tongue or lip | | |
| 6. Have you ever had cold sores or canker sores? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Ice | | |
| 7. Have you ever experienced any of the following problems in your jaw? | | | <input type="checkbox"/> Other _____ | | |
| a) Clicking? | <input type="checkbox"/> | <input type="checkbox"/> | 11. Have you ever had difficult extractions in the past? | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Pain (joint, ear, side of face)? | <input type="checkbox"/> | <input type="checkbox"/> | 12. Have you had any orthodontic work? | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Difficulty in opening or closing? | <input type="checkbox"/> | <input type="checkbox"/> | 13. Have you seen any other dental specialists? | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Difficulty in chewing? | <input type="checkbox"/> | <input type="checkbox"/> | If yes, please list _____ | | |
| | | | _____ | | |
| | | | _____ | | |
| | | | 14. Have you ever had instruction on the correct method of brushing your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 15. Have you ever had instructions on the care of your gums? | <input type="checkbox"/> | <input type="checkbox"/> |

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____
 Signature of patient or parent/legal guardian (if minor) Date

 Signature of dentist Date