David M. Shabluk, D.D.S., P.C.
706 W. Randall
Coopersville, MI 49404

(616)837-6521

www.coopersvilledental.com

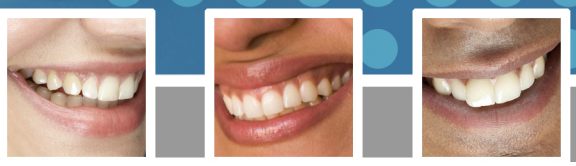

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____

_____ (City) _____ (State) _____ (Zip Code)

RESPONSIBILITY PARTY INFORMATION

The following is for: * ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: * _____ (Last) * _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: * ◯ Male ◯ Female Family Status: * ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: * _____ Email Address: _____

Phone: * _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) Best time to call: _____

Address: * _____

* _____ (City) * _____ (State) * _____ (Zip Code)

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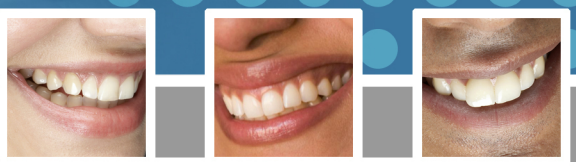

Please tell us how you heard about our office:

Dental Information

What is the name of your previous dental provider?

*

What is the phone number of your previous dental provider?

*

When was your last dental exam?

*

When did you last have dental x-rays taken?

*

When was your last professional dental cleaning?

*

How many times per day do you brush your teeth?

*

How many times per week do you floss?

*

What type of toothbrush do you use?

* ☐ Soft ☐ Medium ☐ Hard ☐ Manual ☐ Electric

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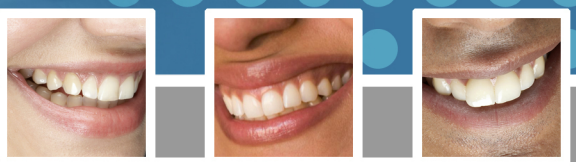

Are you currently experiencing dental pain?

* ◯ Yes ◯ No

If you answered "Yes" to the previous question, what area of the mouth are you experiencing pain and how long have you been experiencing this?

Please indicate if you have any of the following problems/concerns:

- ☐ Discomfort, Clicking or jaw Popping
- ☐ Blisters/Sores in or Around the Mouth
- ☐ Teeth Grinding
- ☐ Bad Breath
- ☐ Stained Teeth
- ☐ Loose teeth
- ☐ Been told that you have gum disease
- ☐ Sensitivity to hot
- ☐ Sensitivity to biting
- ☐ Had problems with previous dental treatment
- ☐ Dissatisfied with the appearance of your teeth
- ☐ Red, Bleeding or Swollen Gums
- ☐ Lost or Broken Filling(s)
- ☐ Broken/Chipped Tooth
- ☐ Food trapped between teeth
- ☐ Locking Jaw
- ☐ Treated for gum disease
- ☐ Sensitivity to cold
- ☐ Sensitivity to sweets
- ☐ Apprehensive about dental treatment
- ☐ Gag easily
- ☐ Other

If you chose "Other", please explain:

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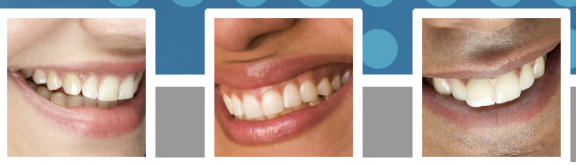

Medical Information

Do you currently require pre-medication (antibiotic) prior to dental appointments?

* ◯ Yes ◯ No

If you answered "Yes" to the previous question, please tell us what condition or procedure you had/ have that requires the premedication:

Do you smoke?

◯ Yes ◯ No

If yes, how many cigarettes do you smoke per day and how many years have you smoked?

Do you use other tobacco products?

◯ Yes ◯ No

If yes, what type of tobacco product do you use and how many years have you used this product?

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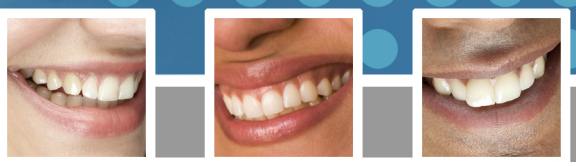

Do you have or have had any of the following diseases, medical conditions or procedures? Please check proper box.

- ☐ Heart Attack
- ☐ Rheumatic Fever
- ☐ Heart Disease
- ☐ Chest Pains
- ☐ Thyroid Disorders
- ☐ Respiratory Problems
- ☐ Stomach Problems
- ☐ Tuberculosis
- ☐ Radiation Treatment
- ☐ Hepatitis
- ☐ Rheumatoid Arthritis
- ☐ Fainting
- ☐ Severe/Frequent Headaches
- ☐ Cosmetic Surgery
- ☐ Difficulty Breathing
- ☐ Anemia
- ☐ Bleeding Disorders
- ☐ Venereal Disease
- ☐ Psychiatric care
- ☐ Stroke
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Scarlet Fever
- ☐ Kidney Disorders
- ☐ Sinus Problems
- ☐ Alcohol Abuse
- ☐ Jaw Problems
- ☐ Tumors
- ☐ HIV/AIDS/ARC
- ☐ Artifical Bones/Joints
- ☐ Seizures
- ☐ Frequent Neck Pain
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Glaucoma
- ☐ Skin Rash
- ☐ Food Allergies
- ☐ Heart Murmur
- ☐ Artificial Valves
- ☐ Congenital Heart Defect
- ☐ Nervousness
- ☐ Liver Disorders
- ☐ Ulcers
- ☐ Drug Abuse
- ☐ Cancer
- ☐ Shingles
- ☐ Arthritis
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Back Problems
- ☐ Asthma
- ☐ Leukemia
- ☐ Low Blood Pressure
- ☐ Herpes
- ☐ Swelling, feet or ankles

List any other medical conditions you have or have had:

*

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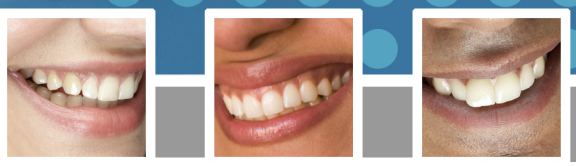

List all medications that you are currently taking:

Do you have any known allergies or had an allergic reaction in the past to any of the following:

- [ ] Local anesthetics ("Novocaine")
- [ ] Latex
- [ ] Tetracycline
- [ ] Ibuprofen
- [ ] Reaction to metals
- [ ] Other
- [ ] Penicillin/Amoxicillin
- [ ] Aspirin
- [ ] Acetaminophen
- [ ] Codeine, Demerol, or other narcotics
- [ ] Sulfa Drugs

Please note any allergies that were not listed above:

Women Only

Are you currently pregnant?

◯ Yes ◯ No

I have reviewed the information and answered all questions to the best of my knowledge. I understand that this information may be shared with other medical offices only as necessary. I will notify the office should any information change in the future.

Signature

*

Today's Date

*

Response Date: