Royal Oak Dental
Dr. Thomas Gilbert

715 North Main Street
Royal Oak, MI 48067

Whom may we thank for referring you to our office:______________________________

Your Name: ______________________________ SS#______________

Address:______________________________

City:______________ State:____________ Zip:____________

Telephone: (Home)______________ (Work):______________

(Cell)______________ (E-Mail):______________

Birth Date:__________ Sex:_____ Marital Status:__________ Spouse Name:______________

Occupation:______________ Employer:______________

If college student, school name: ______________________________

City______________ State_________ Estimated date of grad ______________

Person Responsible For Account

Name: ______________ Relationship: ____________ SS#: ______________

Address: ______________________________

City: ______________ State: ____________ Zip: ______________

Telephone: (Home) ______________ (Work): ______________

Insurance Information

Minor Child- May Need To Complete Both Blocks For Patient Information
Adults- Complete Primary Insured
Dual Coverage? Also Complete Secondary Insured

Primary Insured	Secondary Insured
Last / First / MI	Last / First / MI
Street / City / State / Zip	Street / City / State / Zip
Home # / Work # / Fax# / email	Home # / Work # / Fax# / email
Birthdate (Mo/Day/Year) / Relationship to Patient	Birthdate (Mo/Day/Year) / Relationship to Patient
Employer / Dental Ins Company	Employer / Dental Ins Company
SS# / Subscriber # / Group #	SS# / Subscriber # / Group #

Primary reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation

Dental History

Please Circle

Do you have a specific dental problem? Describe ______________ Yes No
Do you have dental examinations on a routine basis? Last visit______________ Yes No
Do you like your smile? If not, why? ______________ Yes No
Do you ever have clicking, popping or discomfort in the jaw joint?................................ Yes No
Do you Brux or Grind?... Yes No
Do you smoke or chew? Any sores or growths in your mouth? Describe ____________ Yes No

Name of previous dentist (optional):______________________________
Date of last full mouth x-rays (16 small films or panoramic): ______________
May we request a copy of your dental records?... Yes No

Authorization Signature: ______________________________

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

Person to contact in case of emergency

Outside of Immediate Family Household
Name ______________________________
Address ______________________________
City/State/Zip ______________________________
Telephone # ______________________________

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Medical Alerts

Physician's Name ________________________ Date of Last Visit ____________

Address ________________________________ Phone ____________

Please Circle **Y** (yes) if you **HAVE** or **N** (no) if you **Have Not** been treated for the following conditions:

1. Y N Heart Murmurs
2. Y N Rheumatic Fever / Rheumatic Heart Disease
3. Y N Congenital Heart Disease
4. Y N Cardiovascular Stent When______________
5. Y N Artificial Joint Replacement
6. Y N Artificial Heart Valve
7. Y N High Blood Pressure
8. Y N Angina
9. Y N Heart Attack When________________________
10. Y N Arrhythmia What Type____________________
11. Y N Congestive Heart Failure
12. Y N Emphysema
13. Y N Asthma
14. Y N Tuberculosis
15. Y N Kidney Disease
16. Y N Hemodialysis
17. Y N Hepatitis
18. Y N Cirrhosis
19. Y N Alcohol Abuse
20. Y N Ulcers
21. Y N Have you ever been hospitalized for any of the above conditions: Describe ____________________

23. Y N HIV/AIDS
24. Y N Arthritis
25. Y N Stroke
26. Y N Epilepsy
27. Y N Diabetes
28. Y N Hypo / Hyper Thyroidism
29. Y N Prolonged / Excessive Bleeding
30. Y N Hemophilia
31. Y N Liver Disease
32. Y N Anticoagulation Therapy – Blood Thinners
33. Y N Anemia
34. Y N Sickle cell Anemia
35. Y N Cancer
36. Y N Radiation Therapy
37. Y N Chemotherapy
38. Y N Behavioral / Psychiatric Disorders
39. Y N Latex Allergy
40. Y N Are You Pregnant?

Give details of positive findings ____

____

22. Y N Other conditions we should know about? Please List: ____

____

Medications:

Over the Counter ____________________

RX Medications ____________________

Herbal Supplements ____________________

Do you have any allergies? (drug, medicine, food) Y N

Please list: ____________________

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Authorization

I hereby authorize payment directly to Royal Oak Dental. I understand I am responsible for all costs of detal treatment regardless of insurance or third party payors. I authorize Royal Oak Dental to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information I have provided in the dental/medical histories is correct. I grant the right to the office of Royal Oak Dental to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

X ____

(Patient or responsible party)

Date ____________________ State Drivers License ____________________