Derek M. Draft, D.D.S., & Daniel G. Schultze, D.D.S.
3100 Wilson Ave., S.W.
Grandville, MI 49418
(616) 534-7138

Patient Information

Today's Date_____

Name_____
First M.I. Last Mr., Mrs., Miss., Ms.
Birthdate____/____/_____ □Male □Female

Home Address_____

_____

□ Single □ Married □ Divorced □ Widowed □ Separated

Home# _____Pager/Cell #_____

Work# _____ _E-mail_____

Employer_____

Employer Address_____

How long there?_____Occupation_____

Where & when are the best times to reach you?_____

_____SS #_____

Spouses Name_____

Employer_____

Work #_____Birthdate____/____/_____

DENTAL INSURANCE (PRIMARY)

Insurance Co. Name_____

Insurance Co. Address_____

Insurance Co. Phone #_____

Group #(Plan. Local or Policy #)_____

Insured's Name_____Relation_____

Insured's Birthdate__/__/____Insured SS#_____

Insured's Employer_____

SECONDARY INSURANCE

Insurance Co. Name_____

Insurance Co. Address_____

Insurance Co. Phone #_____

Group #(Plan. Local or Policy #)_____

Insured's Name_____Relation_____

Insured's Birthdate__/__/____Insured SS#_____

Insured's Employer_____

In the event of an emergency, is there someone who lives near you that we should contact?

Their Name:_____Relation_____

Work #_____Home#_____

Medical History

Do you have a personal physician □ No □ Yes

Physician's Name:_____

Phone #_____Date of last visit__/__/_____

Your current physical health is □ Good □ Fair □ Poor

Are you currently under the care of a physician □ Yes □ No

Please explain:_____

Are you currently taking any prescription/over the counter drugs □ No □ Yes

Please list each one: _____

_____

Have you ever had any of the following diseases or medical problems?

Y N Heat attack/Stroke	Y N Psychiatric Problems
Y N Cancer/Chemotherapy	Y N Epilepsy/Seizures
Y N Heart Murmur	Y N Diabetes/Tuberculosis
Y N Rheumatic Fever	Y N Drug/Alcohol Abuse
Y N HIV+/AIDS	Y N Venereal Disease
Y N Heart Surgery/Pacemaker	Y N Hemophilia/Anemia
Y N Shingles	Y N Ulcers/Colitis
Y N Mitral Valve Prolapse	Y N Congenital Heart Defect
Y N Kidney Problems	Y N Radiation Treatment
Y N Artificial Bones/Joints	Y N Asthma/Arthritis
Y N Artificial Valves	Y N Hospitalized for any reason
Y N Sinus Problems	Y N Hepatitis
Y N High/Low Blood Pressure	Y N Blood Transfusion
Y N Fever Blisters	Y N Emphysema/Glaucoma
Y N Severe/Frequent Headaches	Y N Smoke
Y N Use Chewing Tobacco	Y N Difficulty Breathing

Please list any serious medical condition(s) that you have ever had:

_____

Are you allergic to any of the following drugs?

Y N Penicillin	Y N Tetracycline	Y N Latex
Y N Aspirin	Y N Dental Anesthetics	Y N Other
Y N Erythromycin	Y N Codeine	

Please list any other drugs you are allergic to:_____

FOR WOMEN:
Are you Pregnant? □No □Yes Week#_____

Are you Nursing? □No □Yes

OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. INITIALS_____ DATE___/___/_____

Comments:_____