

**CHILD REGISTRATION**  
(Please Print Clearly)

Patient's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Father's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Father's E-mail \_\_\_\_\_ Cell Phone \_\_\_\_\_

Father's S.S.# \_\_\_\_\_ Father's Dr. License # \_\_\_\_\_

Father's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer's Address \_\_\_\_\_

Father's Dental Ins. \_\_\_\_\_ Policy # \_\_\_\_\_

Mother's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Mother's E-mail \_\_\_\_\_ Cell Phone \_\_\_\_\_

Mother's S.S.# \_\_\_\_\_ Mother's Dr. License # \_\_\_\_\_

Mother's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer's Address \_\_\_\_\_

Mother's Dental Ins. \_\_\_\_\_ Policy # \_\_\_\_\_

Person Responsible for Account \_\_\_\_\_

Emergency Contact Person \_\_\_\_\_ Phone # \_\_\_\_\_

Reason for Appointment \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_



Steven F. Shwedel, D.D.S., P.C.

And Associates

FAMILY & COSMETIC DENTISTRY

25650 GODDARD ROAD, SUITE A, TAYLOR, MICHIGAN 48180, PHONE: (313) 292-5590

PATIENT NAME \_\_\_\_\_ REG# \_\_\_\_\_

Email address \_\_\_\_\_ Date of birth \_\_\_\_\_

## HEALTH HISTORY FORM

Please **CIRCLE** the appropriate response next to each question below: Yes (Y), No (N), Don't Know (?)

### MEDICAL HISTORY

Do you have or have you had any of the following:

**1. Breathing problems?**

- |                             |   |   |   |
|-----------------------------|---|---|---|
| a. Asthma                   | Y | N | ? |
| b. Emphysema                | Y | N | ? |
| c. Bronchitis               | Y | N | ? |
| d. Tuberculosis             | Y | N | ? |
| e. Shortness of breath      | Y | N | ? |
| f. Other breathing problems | Y | N | ? |

Explain: \_\_\_\_\_

**2. Heart or circulation problems?**

- |  |   |   |   |
|--|---|---|---|
| a. High blood pressure                 | Y | N | ? |
| b. Heart attack                        | Y | N | ? |
| c. Angina or chest pain                | Y | N | ? |
| d. Irregular heart beat                | Y | N | ? |
| e. Rheumatic fever                     | Y | N | ? |
| f. Heart murmur                        | Y | N | ? |
| g. Mitral valve prolapse               | Y | N | ? |
| h. Damage to heart valves              | Y | N | ? |
| i. Heart valve replacement             | Y | N | ? |
| j. Pacemaker/other cardiac device      | Y | N | ? |
| k. Congestive heart failure            | Y | N | ? |
| l. Swollen ankles                      | Y | N | ? |
| m. Other heart or circulation problems | Y | N | ? |

Explain: \_\_\_\_\_

**3. Kidney or urinary problems?**

- |                          |   |   |   |
|--------------------------|---|---|---|
| a. Kidney disease        | Y | N | ? |
| b. Dialysis              | Y | N | ? |
| c. Frequent urination    | Y | N | ? |
| d. Other kidney problems | Y | N | ? |

Explain: \_\_\_\_\_

**4. Nervous system problems?**

- |   |   |   |   |
|---|---|---|---|
| a. Stroke or transitory ischemic attack | Y | N | ? |
| b. Fainting spells                      | Y | N | ? |
| c. Convulsions, seizures or epilepsy    | Y | N | ? |
| d. Other nervous system problems        | Y | N | ? |

Explain: \_\_\_\_\_

**5. Head and neck problems?**

- |   |   |   |   |
|---|---|---|---|
| a. Nose or sinus problems                 | Y | N | ? |
| b. Swollen glands                         | Y | N | ? |
| c. Oral cancer                            | Y | N | ? |
| d. Impairment of hearing, sight or speech | Y | N | ? |

- |                                 |   |   |   |
|---------------------------------|---|---|---|
| e. Frequent or severe headaches | Y | N | ? |
| f. Other head and neck problems | Y | N | ? |

Explain: \_\_\_\_\_

**6. Hormone or gland problems?**

- |  |   |   |   |
|--|---|---|---|
| a. Thyroid disease (hypothyroidism, hyperthyroidism) | Y | N | ? |
| b. Diabetes  | Y | N | ? |
| c. Adrenal or pancreatic disease                     | Y | N | ? |
| d. Any other hormone/gland disease                   | Y | N | ? |

Explain: \_\_\_\_\_

**7. Muscle, bone or skin problems?**

- |                                       |   |   |   |
|---------------------------------------|---|---|---|
| a. Arthritis                          | Y | N | ? |
| b. Osteoporosis                       | Y | N | ? |
| c. Artificial joint placement         | Y | N | ? |
| d. Hives or skin rash                 | Y | N | ? |
| e. Skin cancer                        | Y | N | ? |
| f. Back problems                      | Y | N | ? |
| g. Other muscle, bone or skin disease | Y | N | ? |

Explain: \_\_\_\_\_

**8. Stomach, liver or intestinal problems?**

- |  |   |   |   |
|--|---|---|---|
| a. Liver disease                               | Y | N | ? |
| b. Hepatitis                                   | Y | N | ? |
| c. Acid reflux (GERD)                          | Y | N | ? |
| d. Ulcers                                      | Y | N | ? |
| e. Other stomach, intestinal or liver problems | Y | N | ? |

Explain: \_\_\_\_\_

EXAMINER'S COMMENTS \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**9. Allergic reactions or other problems?**

- a. Seasonal allergies Y N ?
- b. Allergy, reaction or intolerance to:
  - Penicillin Y N ?
  - Erythromycin Y N ?
  - Codeine Y N ?
  - Latex Y N ?
  - Local anesthetics Y N ?
  - Foods/flavoring Y N ?
  - Other substances Y N ?

Explain: \_\_\_\_\_  
\_\_\_\_\_

**10. Blood or immune system problems?**

- a. Cancer of any type Y N ?
- b. Organ or bone marrow transplant Y N ?
- c. Lupus Y N ?
- d. Multiple sclerosis Y N ?
- e. Anemia Y N ?
- f. Hemophilia Y N ?
- g. AIDS/HIV Y N ?
- h. Frequent nosebleeds, increased bruising or bleeding Y N ?
- i. Are you taking any blood thinners? Y N ?
- j. Have you had chemotherapy or radiation treatment? Y N ?
- k. Other problems with the blood or immune system? Y N ?

Explain: \_\_\_\_\_

**11. What medications or other substances are you taking or have you taken in the past 2 months?**

- a. Please list all prescription and non-prescription drugs including aspirin, birth control pills, herbal medications or other supplements. Write "none" if you are not taking any medications or other substances.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- b. Have you ever taken the drugs Fenfluramine(Fen-phen), Pondimin, or Dexfenfluramine(Redux)? Y N ?
- c. Have you taken or are you taking drugs to control bone loss? (ie. Fosamax®) Y N ?

**12. Personal History**

- a. Have you ever been hospitalized, had major surgery or been seriously hurt? Y N ?  
If yes, what type and when \_\_\_\_\_
- b. Have you had or do you have any sexually transmitted diseases (syphilis, gonorrhea, herpes, etc.)? Y N ?
- c. Do you need any special accommodations for dental treatment? Y N ?
- d. Are you pregnant? Y N ?
- e. Have you ever used tobacco products? Y N ?
- f. Are you currently using tobacco products? Y N ?

What type and how often \_\_\_\_\_

- g. How many alcohol containing drinks do you consume a week? \_\_\_\_\_
- h. Do you use or have you used recreational drugs? Y N ?
- i. Have you ever had a problem with alcohol and/or drugs? Y N ?
- j. Do you have mental health problems? Y N ?
- k. When was your last visit to a physician (medical doctor)? \_\_\_\_\_
- l. Do you have a physician (medical doctor)? Y N ?

If yes, please provide the Name, Address and Telephone \_\_\_\_\_  
\_\_\_\_\_

EXAMINER'S COMMENTS \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## DENTAL HISTORY

1. What is the reason for your dental visit? \_\_\_\_\_

---

2. Have you ever had any problems following dental treatment? Y      N      ?  
If yes, please explain \_\_\_\_\_
3. Have you ever had a bad or unusual reaction to local anesthetic? Y      N      ?
4. Have you ever had a severe injury to your face, teeth or jaws? Y      N      ?
5. Have you ever had surgery in your mouth or on your lips? Y      N      ?
6. Have you ever had periodontal treatment to your gums? Y      N      ?
7. Have you ever had orthodontic treatment to straighten your teeth? Y      N      ?
8. Have you ever had extraction (pulling) of any teeth? Y      N      ?
9. Have you ever had endodontics (root canals) on any teeth? Y      N      ?
10. Have you had any missing teeth replaced by a removable denture, fixed bridge or an implant? Y      N      ?
11. Have you ever worn a bitesplint/nightguard? Y      N      ?
12. Have you had a recent toothache? Y      N      ?
13. Are your teeth sensitive to hot, cold or pressure? Y      N      ?
14. Do you have bleeding gums? Y      N      ?
15. Do you have trouble chewing? Y      N      ?
16. Do you clench or grind your teeth? Y      N      ?
17. Do you have difficulty opening your mouth as wide as you would like? Y      N      ?
18. Do your jaw joints or muscles hurt? Y      N      ?
19. Does your jaw click, pop or lock when you chew? Y      N      ?
20. Do you experience a dry mouth? Y      N      ?
21. Do you have sores in or around your mouth? Y      N      ?
22. Please circle the amount of sugar in your diet. small   moderate   high
23. When was the last time your teeth were cleaned at a dental office? \_\_\_\_\_
24. How often do you brush? \_\_\_\_\_
25. How often do you use dental floss? \_\_\_\_\_
26. Are you satisfied with the appearance of your teeth? Y      N      ?  
If No, Why not? \_\_\_\_\_
27. Do you have any questions, concerns, or additional information you would like us to know before we treat you? Y      N      ?  
If Yes, please specify? \_\_\_\_\_

---

28. How do you feel about going to the dentist (please circle) Scared      Apprehensive      No problem

EXAMINER'S COMMENTS \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I certify that to the best of my knowledge the above information is complete and accurate.

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

If other than the patient, indicated relationship \_\_\_\_\_

Reviewed by Dr. \_\_\_\_\_

---

**Review and update of questionnaire:**

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

If other than the patient, indicated relationship \_\_\_\_\_

Changes \_\_\_\_\_

Update reviewed by Dr. \_\_\_\_\_

**Review and update of questionnaire:**

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

If other than the patient, indicated relationship \_\_\_\_\_

Changes \_\_\_\_\_

Update reviewed by Dr. \_\_\_\_\_

**Review and update of questionnaire:**

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

If other than the patient, indicated relationship \_\_\_\_\_

Changes \_\_\_\_\_

Update reviewed by Dr. \_\_\_\_\_

The health history form should be updated at least every 6 months  
and a new form must be filled out every 2 years.

# Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgment, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

**Steven F. Shwedel D.D.S., P.C.**

## Patient Acknowledgement

*Please sign this form below under the heading "acknowledgement" to acknowledge that you have today received a copy of our notice of privacy practices.*

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Patient Name (please print)

Date: \_\_\_\_\_

### For office use only

Patient Refused to Sign

The following circumstances prohibited the patient from signing the Acknowledgment:

\_\_\_\_\_  
An emergency situation prevented the patient from signing the Acknowledgement.

\_\_\_\_\_  
Office Personnel (signature)

\_\_\_\_\_  
Office Personnel (print name)

Date: \_\_\_\_\_

## Patient Consent

*Please sign this form below under the heading "Consent" to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.*

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Patient Name (please print)

Date: \_\_\_\_\_