Dr. Ronald Olszewski D.D.S
6640 28th Street SE, Grand Rapids, MI 49546

Patient Information Date _____

Patient's Name _____ M___ F___

Address _____ City _____ Zip _____ State ___

Cell Phone _____Email_____

Birthdate _____ Social Security #_____

Whom may we thank for referring to our office? _____

By ☐ providing my phone number, I consent to receive SMS text messages from Always A Smile for appointment reminders, marketing messages, and general two-way communication. Msg frequency varies. Msg&data rates may apply. Reply HELP for support. Reply STOP to opt out. Refer to our [privacy policy and [terms and conditions for more information.

Responsible Party/Primary Insurance Information

Name _____Birthdate _____Relation to patient _____

Address (if different from patient)_____

Social Security #_____ Cell Phone _____

Employer _____ Insurance Company _____

Policy #_____ Group #_____ Is there secondary Insurance _____

Emergency Contact

Name _____ Relationship _____

Address _____Phone _____

Dental Health

Reasons for today's visit? _____

Have you had any serious trouble with previous dental work? If yes, please explain:

_____

When was your last dental visit? _____Previous dentist name_____

How often do you brush? _____ How often do you floss? _____

	Y	N
Do you snore?	___	___
Do you feel like you have bad breath?	___	___
Do you have sensitivity to hot/cold/chewing?	___	___
Do you currently use any tobacco/nicotine products?	___	___
Do you currently use any products containing THC?	___	___

Medical History

Name of Physician _____ Phone number_____
Are you currently under care of a physician or receiving ongoing medical care? _____
Are you taking any prescription or over the counter prescriptions? _____

Medication:	Dosage:	How often taken:	Reason for prescription:
1.			
2.			
3.			
4.			

Please list all previous surgeries:

_____

	Y	N
Are you currently pregnant?	____	_____
Are you currently taking birth control?	____	_____
Are you currently breastfeeding?	____	_____
Do you have any artificial joints, heart valves, implants, or prosthesis?	____	_____
Have you ever been told you need to pre-medicate for a dental procedure?	____	_____

PLEASE LIST ALL ALERGIES TO MEDICATIONS (LIST NONE IF YOU HAVE NONE)

_____

Please check any pertinent health history below

	Yes	No		Yes	No
Heart Disease	____	____	Asthma	____	____
Heart murmur	____	____	Hay Fever/Hives	____	____
Rheumatic Fever	____	____	Sinus Trouble	____	____
Abnormal Blood pressure	____	____	Hepatitis A, B, C	____	____
Ulcers	____	____	Arthritis	____	____
TB/lung disease	____	____	Chest Pain	____	____
Diabetes- Type 1	____	____	AIDS or HIV	____	____
Diabetes- Type 2	____	____	Glaucoma	____	____
Epilepsy	____	____	Seizures	____	____
Anemia	____	____	Parkinson	____	____
Cold Sores/herpes	____	____	Dementia	____	____
Hemophilia	____	____	Autoimmune Disease	____	____
Stroke	____	____	Bleeding problems	____	____
Swollen feet	____	____	Chemical Dependency	____	____
Nervous problems	____	____	Radiation treatment	____	____
Lupus	____	____	Sjogren's Syndrome	____	____
Head injury	____	____			
Latex Allergy	____	____	Any other disease not listed:		
Jaundice	____	____			
Liver disease	____	____	If yes, please list _____		

I have completed this form fully and completely to the best of my knowledge. If I ever have a change in my health or medications, I will notify my provider immediately. I hereby give consent to treatment for myself or the named individual on this form

Signature _____ Date _____

Updated initials and date: _____ _____ _____ _____ _____ _____