Patient #_____
Social Security #_____
Date _____

927 S. Beechtree
Suite # 5
Grand Haven, MI 49417
(616) 844-5555

Jeffrey J. Fritz DDS PC

Robert A. Kamminga DDS

Welcome to Beechtree Family Dentistry.

Thank you for trusting us with your dental care.
We promise to do our best to provide you with the finest care available.

■ Patient Information

Name _____ Birth Date _____
Home Phone ( ) _____ Cell Phone ( ) _____
Address _____ City_____ State_____ Zip Code_____
Check Appropriate Box: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated
Patient's or Parent's Employer _____ Work Phone ( ) _____
Business Address_____ City_____ State _____ Zip Code_____
Spouse or Parent's Name_____ Employer _____Work Phone ( ) _____
If Patient is a student, Name of School/College _____ City _____ State _____
Whom may we Thank for referring you? _____
Person to contact in case of emergency _____ Phone ( ) _____

■ Responsible Party

Name of person responsible for this account _____
Relation to Patient _____ Address _____
City _____ State _____ Zip Code _____ Home Phone ( ) _____
Drivers License # _____ Birth Date _____ Bank _____
Employer _____ Work Phone ( ) _____
Currently a patient in our office? ❑ Yes ❑ No

■ Insurance Information

Name of Insured _____ Relation to Patient _____
Birth Date _____ Social Security # _____ Date Employed _____
Employer _____ Work Phone ( ) _____
Employer Address _____ City _____ State _____ Zip Code _____
Insurance Company _____ Union or Local # _____

■ Additional Insurance

Name of Insured _____ Relation to Patient _____
Birth Date _____ Social Security # _____ Date Employed _____
Employer _____ Work Phone ( ) _____
Employer Address _____ City _____ State _____ Zip Code _____
Insurance Company _____ Union or Local # _____

Over

■ Dental History

Reason for today's visit _____
Former Dentist _____
Address _____ City_____ State _____ Zip Code_____
Date of last dental visit _____ Date of last dental x-rays _____
Check (✓) if you have any of the following :

❑ Bad breath
❑ Bleeding gums
❑ Clicking or popping jaw
❑ Food collection between the teeth
❑ Grinding teeth
❑ Loose teeth or broken fillings
❑ Periodontal treatment
❑ Sensitivity to cold
❑ Sensitivity to heat
❑ Sensitivity to sweets
❑ Sensitivity when biting
❑ Sores or growths in your mouth

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

■ Medical History

Physician's Name _____ Date of last visit _____
Have you had any serious illnesses or operations? ❑ Yes ❑ No If yes, describe _____
Have you ever had a blood transfusion? ❑ Yes ❑ No If yes, give approximate date(s) _____
(Women) Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking birth control pills? ❑ Yes ❑ No

Check (✓) if you have any of the following:

❑ Aids/HIV positive
❑ Anemia
❑ Arthritis, Rheumatism
❑ Artificial Heart Valves
❑ Artificial Joints
❑ Asthma
❑ Back Problems
❑ Blood Disease
❑ Cancer
❑ Chemical Dependency
❑ Chemotherapy
❑ Circulatory Problems
❑ Cortisone Treatments
❑ Cough, Persistent
❑ Cough up Blood
❑ Diabetes
❑ Epilepsy
❑ Fainting
❑ Glaucoma
❑ Headaches
❑ Heart Murmur
❑ Heart Problems
Describe _____
❑ Hemophilia
❑ Hepatitis
❑ High Blood Pressure
❑ Jaw Pain
❑ Kidney Disease
❑ Liver Disease
❑ Mitral Valve Prolapse
❑ Nervous Problems
❑ Pacemaker
❑ Peanut Allergy
❑ Psychiatric Care
❑ Radiation Treatment
❑ Respiratory Disease
❑ Rheumatic Fever
❑ Scarlet Fever
❑ Shortness of Breath
❑ Skin Rash
❑ Stroke
❑ Swelling of the Feet or Ankles
❑ Thyroid Problems
❑ Tobacco Habit
❑ Tonsillitis
❑ Tuberculosis
❑ Ulcer
❑ Venereal Disease

Do you have any drug allergies or have you ever had an adverse reaction to any medication?
If so, what _____
Have you ever responded adversely to medical or dental treatment? _____
Are you taking any medication at this time? ❑ Yes ❑ No If yes, what? _____
Are you under the care of a physician? ❑ Yes ❑ No
For what conditions? _____
Have you ever been told by a physician or dentist that you need an antibiotic before having dental work or surgeries performed? ❑ Yes ❑ No If so, have you taken your pre-medication? ❑ Yes ❑ No

■ Authorization & Release

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.
Signature of patient or parent if minor _____ Date _____

■ Additional Information

Payment is due in full at time of treatment unless prior arrangements have been approved. As a courtesy to our patients we will bill your insurance carrier, however, any balance not covered will be due at time of service. We accept all major credit cards and financing may be available through CareCredit.