Sylvan S. Stern DDS
17040 W. Twelve Mile Road #150
Southfield, MI 48076 248-559-0995

Patient Information

Today's Date _____

Patient Name _____

Address _____

City _____

State _____ Zip _____

Home Phone _____

Work Phone _____

Cell Phone _____

E-mail _____

Preferred phone # to confirm appointments _____

Sex ☐ M ☐ F Age _____

Birthdate _____

Social Security Number _____

☐ Married ☐ Single ☐ Minor

Occupation _____

Employer _____

Address _____

_____

Emergency Contact _____

Home Phone _____

Work Phone _____

Cell Phone _____

Spouse's Work _____

Spouse's Cell _____

Whom may we thank for referring you? _____

Who is responsible for this account? _____

Relationship to Patient _____

Dental Insurance

Insurance Co. _____

Enrollee ID _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Relationship to Patient _____

Birthdate _____ Social Security # _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverag with

_____ and assig
Name of Insurance Company(s)

directly to Dr. Sylvan S. Stern D.D.S.. all insurance benefits, any, otherwise payable to me for services rendered. I understan that I am financial responsible for all charges whether or not pai by insurance. I authorize the use of my signature on all insuranc submissions.

The above-named dentist may use my health care informatio and may disclose such information to the above-named Insuranc Company(s) and their agents for the purpose of obtainin payment for services and determining insurance benefits or th benefits payable for related services.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____
Date Relationship to Patient

Dental History

Reason for today's visit _____

_____

Previous Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" to indicate if you have had any of the following:

Bad breath	☐ Yes	Burning sensation on tongue	☐ Yes	Mouth pain	☐ Yes
Bleeding gums	☐ Yes	Cigarette/pipe/cigar smoking	☐ Yes	Orthodontic treatment	☐ Yes
Blisters on lips/in mouth	☐ Yes	Clicking or popping jaw	☐ Yes	Pain around ear	☐ Yes
Broken fillings	☐ Yes	Dry mouth	☐ Yes	Periodontal treatment	☐ Yes
		Fingernail biting	☐ Yes	Sensitivity to cold	☐ Yes
		Food collection between teeth	☐ Yes	Sensitivity to heat	☐ Yes
		Grinding teeth	☐ Yes	Sensitivity to sweets	☐ Yes
		Growth in mouth	☐ Yes	Sensitivity to biting/chewing	☐ Yes
		Gums swollen or tender	☐ Yes	Sores or growths in your mouth	☐ Yes
		Jaw pain	☐ Yes	Tooth Pain	☐ Yes
		Lip or cheek biting	☐ Yes		
		Loose teeth	☐ Yes	How often do you floss?	_____
		Mouth breathing	☐ Yes	How often do you brush?	_____

Health History

Medical Doctor's Name _____

Address _____ Phone _____

Place a mark on "yes" to indicate if you have had any of the following:

Acid Reflux	☐ Yes	Epilepsy	☐ Yes	Psychiatric Care	☐ Yes
AIDS/HIV	☐ Yes	Fainting or dizziness	☐ Yes	Radiation Treatment	☐ Yes
Anemia	☐ Yes	Glaucoma	☐ Yes	Respiratory Disease	☐ Yes
Arthritis	☐ Yes	Headaches	☐ Yes	Rheumatic Fever	☐ Yes
Artificial Heart Valve	☐ Yes	Heart Attack	☐ Yes	Scarlet Fever	☐ Yes
Artificial Joint	☐ Yes	Heart Problems	☐ Yes	Shortness of Breath	☐ Yes
Asthma	☐ Yes	Heart Valve Replacement	☐ Yes	Sinus Trouble	☐ Yes
Back Problems	☐ Yes	Hepatitis Type_____	☐ Yes	Skin Rash	☐ Yes
Birth Control Pills	☐ Yes	Herpes	☐ Yes	Special Diet	☐ Yes
Bleeding abnormally, with extractions or surgery	☐ Yes	High Blood Pressure	☐ Yes	Stent	☐ Yes
		Insulin Dependent	☐ Yes	Stroke	☐ Yes
Blood Disease	☐ Yes	Jaundice	☐ Yes	Swollen Feet or Ankles	☐ Yes
Cancer	☐ Yes	Jaw Pain	☐ Yes	Swollen Neck Glands	☐ Yes
Chemical Dependency	☐ Yes	Joint Replacement	☐ Yes	Thyroid Problems	☐ Yes
Chemotherapy	☐ Yes	Kidney Disease	☐ Yes	Tonsillitis	☐ Yes
Circulatory Problems	☐ Yes	Liver Disease	☐ Yes	Tuberculosis	☐ Yes
Congenital Heart Lesions	☐ Yes	Low Blood Pressure	☐ Yes	Tumor or growth on head or neck	☐ Yes
Contact Lenses	☐ Yes	Mitral Valve Prolapse	☐ Yes	Tumor or growth in mouth	☐ Yes
Cortisone Treatments	☐ Yes	Nervous Problems	☐ Yes	Ulcer	☐ Yes
Cough, persistent or bloody	☐ Yes	Organ Transplant	☐ Yes	Venereal Disease	☐ Yes
Diabetes	☐ Yes	Pacemaker	☐ Yes	Weight Loss	☐ Yes
Emphysema	☐ Yes	Pregnant? Due Date_____			

Medications

Pharmacy Name _____

Pharmacy Address _____

Pharmacy Phone _____

List any Medications – Vitamins – Supplements you are taking:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Allergies

- ☐ Penicillin
- ☐ Erythromycin
- ☐ Clindamycin
- ☐ Azithromycin
- ☐ Clarithromycin
- ☐ Keflex
- ☐ Tetracycline
- ☐ Sulfa
- ☐ Aspirin
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Other: _____

_____

_____

Patient Signature

_____

Print Name

We will take reasonable steps to provide free-of-charge language assistance services to people who speak languages we are likely to hear in our practice and who don't speak English well enough to talk to us about the dental care we are providing.