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## PATIENT HEALTH HISTORY

Name: First, Middle, Last			Sex
Birth Date	Marital Status	Social Security Number	
Address (Street, City, State, Zip Code)			
Cell Phone	Email	Home Phone	Office Phone
Business Name and Address		Occupation	
How did you hear about us : Dentist referral      Patient referral      Online      Paper advertisement      Other (Explain):			
Referred to this office by (Dentist Name /Patient name)			
Emergency Contact Person	Relation	Phone	
Person Responsible for Payment of Account	Relation	Phone	
Address			

## DENTAL INSURANCE INFORMATION

### *Primary Insurance Company*

Name & Address	Subscriber Social Security Number
Subscriber's Name	Group or Company Name
Group Number	Patient Relationship to Subscriber (self, spouse, child, etc.)

### *Secondary Insurance Company*

Name & Address	Subscriber Social Security Number
Subscriber's Name	Group or Company Name
Group Number	Patient Relationship to Subscriber (self, spouse, child, etc.)

## MEDICAL HISTORY

Medical Doctor's Name	Address	Phone
Date of My Last Physical Examination	Results	
Are you taking any medication at the present time? If yes, what?		
Are you sensitive or allergic to any medicine? If yes, what?		

Have you had or are you:

- |     |    |                                |     |    |   |
|-----|----|--------------------------------|-----|----|---|
| Yes | No | Asthma                         | Yes | No | Heart Disease or Stroke                               |
| Yes | No | Diabetes (Type 1 or 2)         | Yes | No | Total Joint Replacement (Hip, Shoulder)               |
| Yes | No | High Blood Pressure            | Yes | No | Low Blood Pressure                                    |
| Yes | No | Psychiatric Treatment          | Yes | No | COPD / Pneumonia                                      |
| Yes | No | Blood Transfusion              | Yes | No | Epilepsy or Seizure                                   |
| Yes | No | Arthritis                      | Yes | No | HIV Positive / AIDS                                   |
| Yes | No | Ulcers (Stomach or Intestinal) | Yes | No | Pacemaker   |
| Yes | No | Fainting or Dizzy Spells       | Yes | No | Heart Murmur  |
| Yes | No | Hepatitis                      | Yes | No | Osteoporosis or Osteopenia                            |
| Yes | No | Kidney Disease                 | Yes | No | Chemotherapy/Radiation (Cancer, Leukemia)             |
| Yes | No | Thyroid Disease (or Goiter)    | Yes | No | Smoking: No. of Cigarettes _____ / No. of Years _____ |
| Yes | No | Other: _____                   | Yes | No | Alcohol use: No. of Drinks _____ / No. of Years _____ |

- Yes No Have you ever had excessive bleeding from a cut or wound?  
 Yes No Do you bruise easily?  
 Yes No Do you have pain in the chest upon exertion?  
 Yes No Do you have shortness of breath after mild exercise?  
 Yes No Do you have frequent severe headaches?  
 Yes No Are you under abnormal stress? (e.g., marital, business, or social)

Yes No Do you have any disease, condition, or problem not listed above?  
 If yes, explain: \_\_\_\_\_

**Females**

- Yes No Did you have any complications during pregnancy (if you have never been pregnant, answer no)  
 Yes No Are you pregnant? (date of delivery \_\_\_\_\_)  
 Yes No Are you taking oral contraceptives (birth control pills)?

**Dental History**

- Yes No Have you had any serious trouble associated with any previous dental treatment?  
 If yes, explain: \_\_\_\_\_  
 Yes No Do you bleed excessively after tooth extraction?  
 Yes No Have you had undesirable reactions to local or general anesthetics (e.g., Novocain or gas)?  
 Yes No Do you clench or grind your teeth?  
 Yes No Are you dissatisfied with the appearance of your teeth?  
 Yes No Have you had excessive swelling or pain after oral surgery?  
 Yes No Do you have bleeding gums?  
 Yes No Do you have a bad taste in your mouth?  
 Yes No Does food pack between your teeth?  
 Yes No Does your jaw click or pop when you chew?  
 Yes No Have you ever received treatment for periodontal disease?  
 Yes No Are you willing to become actively involved in the treatment of your periodontal disease?

How satisfied are you about your smile (Explain briefly):
Briefly state your feelings toward dentures
What is your chief complaint concerning your mouth or teeth?

To the best of my knowledge, all of the above answers are true and correct.  
 If I have any change in my health, I will inform Dr. Kinaia and Michigan Periodontics and Implants Office immediately.

\_\_\_\_\_  
 Signature of Patient/Guardian

\_\_\_\_\_  
 Date