MICHIGAN PERIODONTICS & IMPLANTS

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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 / COPD / Pneumonia
Yes No Diabetes (Type 1 or 2)
Yes No High Blood Pressure
Yes No Psychiatric Treatment
Yes No Blood Transfusion
Yes No Arthritis
Yes No Ulcers (Stomach or Intestinal)
Yes No Fainting or Dizzy Spells
Yes No Hepatitis
Yes No Kidney Disease
Yes No Thyroid Disease (or Goiter)
Yes No Other: ____________________

Yes No Heart Disease or Stroke
Yes No Total Joint Replacement (Hip, Shoulder)
Yes No Low Blood Pressure
Yes No High Cholestrol
Yes No Epilepsy or Seizure
Yes No HIV Positive / AIDS
Yes No Pacemaker
Yes No Heart Murmur
Yes No Osteoporosis or Osteopenia
Yes No Chemotherapy/Radiation (Cancer, Leukemia)
Yes No Smoking: No. of Cigarettes ______ / No. of Years ______
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