PATIENT HEALTH HISTORY FORM

Date: ___________

2955 Golfside Road | Ypsilanti, MI 48197 | (734) 434-4400

I. PATIENT INFORMATION

Name	SSN	I prefer to be called:
Home Address	City, State, Zip	Cell Phone ( )
Employer/Occupation	□ Male □ Female	Work Phone ( )
Email Address	Birthdate:	Home Phone ( )

Marital Status: □ Single □ Married □ Divorced □ Widowed

II. INSURANCE

Primary Dental Insurance Company: ________________ Group #: ___________ Subscriber ID: ____________
Subscriber Name: _________________________________ Birthdate: __________

Secondary Dental Insurance Company: ______________ Group #: ___________ Subscriber ID: ____________
Subscriber Name: _________________________________ Birthdate: __________

III. RESPONSIBLE PARTY

Name	Relationship	Home Phone ( )
Home Address	City, State, Zip	Cell Phone ( )

IV. SPOUSE INFORMATION (Initial below if same as above)

Spouses Name	Cell Phone ( )
Email Address	Work Phone ( )

V. Emergency Contact: In the event of an emergency, please contact:

Name: Relationship: Phone: ( )

VI. DENTAL HEALTH & HISTORY

What is the reason of your visit today? ______________________________
Previous Dentist: ______________________ City/State:________________
Has your Doctor told you that you require antibiotics before dental treatment? □ Yes □ No
Are you currently in pain? □ Yes □ No
What are your dental priorities? ___________________________________
Your currently dental health is: □ Good □ Fair □ Poor
Do you like your smile? □ Yes □ No
How many times a week do you floss? _____
How many times a day do you brush? ______
Type of bristles? □ Hard □ Medium □ Soft

Please check all that apply:
□ I clench or grind during the day or night
□ My gums bleed while brushing or flossing
□ My gums feel tender or swollen
□ I avoid brushing certain areas due to pain
□ I have problems eating
□ I have had facial or jaw surgery
□ I have had orthodontics
□ I want whiter teeth
□ I want an improved smile
□I want straighter teeth

VII. MEDICAL HISTORY

Primary Physician's Name: ____________________ Primary Physician's Phone #: ________________________
□ I'm currently under a physician's care for: ____
□ I have had major surgery: Year: _____ Operation: _______________

I consider my overall health to be: □ Excellent □ Good □ Fair □ Poor
Do you have or have you had any of the following? Please check all that apply:

VIII. ALLERGIES

Please check all that apply:
□ Aspirin
□Ibuprofen
□Penicillin / Amoxicillin
□ Codeine
□ Local Anesthetics
□ Latex, Metals, Plastics
□ Acrylic
□ Sulfa Drugs
□ Erythromycin
□ Others, please list: __________________

IX. MEDICATIONS

Please list all medications you are currently taking:
(Please attach a list if you need additional space)
Medicine: ______________ Medicine: ______________
Medicine: ______________ Medicine: ______________
Medicine: ______________ Medicine: ______________

Other comments:
____
____