



## Patient Information And Medical History

Name \_\_\_\_\_ Male Female  
(Last) (First) (Middle)

By what name do you prefer to be called? \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

If it was from Internet what words did you use to search for us (example: Southfield dentist) \_\_\_\_\_

Would you like to be included in our email program and qualify for discounts on your dental work? Yes No

Telephone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Email Address \_\_\_\_\_

Birth Date \_\_\_\_\_ Social Security Number \_\_\_\_\_

Street Address \_\_\_\_\_ Apt./Suite \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

What is the name of your physician? \_\_\_\_\_ Date of your last physical exam \_\_\_\_\_

Physician Address \_\_\_\_\_

Physician Phone# \_\_\_\_\_

### Dental History

Do you visit the dentist regularly?	Yes	No								
Do your gums bleed?	Yes	No								
Do you want to keep your remaining teeth?	Yes	No								
Do you smoke or chew tobacco?	Yes	No								
Do you have any sore spots in your mouth?	Yes	No								
Are your teeth sensitive?	Yes	No								
Do you suffer with migraines or other forms of headaches?	Yes	No								
Do your jaws pop or click when you eat?	Yes	No								
Do you clench your teeth?	Yes	No								
How do you feel about your teeth 10 – highest / 1 - lowest	1	2	3	4	5	6	7	8	9	10

Please describe your specific dental problem:

\_\_\_\_\_  
\_\_\_\_\_

What are three things you would change about your smile?

- 1.
- 2.
- 3.



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What have you liked the most about a dental office? \_\_\_\_\_

What have you liked the least about a dental office? \_\_\_\_\_

What type of fillings do you prefer: Silver/Black Gold White

Would you like a complimentary breath (halitosis) analysis Yes No

**LIST ALL CURRENT MEDICATIONS THAT YOUR ARE TAKING:**

	Insured	Relation	Birth Date	Insurance Company	Insurance Phone #	Group #	Social Security #
<b>Primary Insurance</b>							

Employer name \_\_\_\_\_ Employer Phone # \_\_\_\_\_

	Insured	Relation	Birth Date	Insurance Company	Insurance Phone #	Group #	Social Security #
<b>Secondary Insurance</b>							

Employer name \_\_\_\_\_ Employer Phone # \_\_\_\_\_

**IN CASE OF EMERGENCY CONTACT:** (Close family member not living with you)

Name \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_ Relationship \_\_\_\_\_

To the best of my knowledge, all of the above answers are correct. I shall inform the staff and the doctor about my changes in my health status at each appointment.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**Health History reviewed by doctor on: \_\_\_\_\_ Significant findings and contradictions:**