PATIENT INFORMATION HEALTH HISTORY

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- 1616 Gratiot Blvd. · Marysville, MI 48040
  810-364-7601 · www.pgsdentistry.com
- 251 S. Main Street · Romeo, MI 48065
  586-752-9781 · www.pgsdentistry.com
- 51813 Gratiot Ave. · Chesterfield, MI 48051
  586-846-4145 · www.pgsdentistry.com
- 26250 Crocker Blvd. · Harrison Twp., MI 48045
  586-267-5265 · www.pgsdentistry.com
- 22524 Greater Mack Ave. · St. Clair Shores, MI 48080
  586-800-PGSI · www.pgsdentistry.com

Today's Date_____

ABOUT YOU

Name:_____ I prefer to be called _____ ☐ Male ☐ Female Age:____

Home Address:_____ City:_____ State:_____ Zip:_____

Birthday:_____ SS#:_____ Driver's License#:_____

Employer:_____ Occupation: _____

☐ Single ☐ Married ☐ Divorced Spouse's Name: _____

Who can we thank for referring you?_____

CONTACT INFORMATION

Home Phone:_____ Email: _____

Work Phone:_____ Cell Phone: _____

How would you like us to confirm your appointments: ☐ Home Phone ☐ Cell Phone ☐ Text ☐ Email

WHOM SHOULD WE CONTACT IN CASE OF AN EMERGENCY

Name:_____ Relationship:_____

Home Phone:_____ Work#:_____ Cell#: _____

Person responsible for account: _____

DENTAL INSURANCE

Primary Dental Insurance:

Name: _____

Phone: _____

Group: _____ ID# _____

Insured Person's Information:

Name: _____

Birthday:_____ SS#: _____

Employer:_____

Relationship to patient: _____

Secondary Dental Insurance:

Name: _____

Phone: _____

Group: _____ ID# _____

Insured Person's Information:

Name: _____

Birthday:_____ SS#: _____

Employer:_____

Relationship to patient: _____

DENTAL HISTORY

Why have you come to the dentist today?

_____

Have you ever been treated for periodontal/gum disease? ☐ Yes ☐ No

Do you have a night guard? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Are you missing any teeth? ☐ Yes ☐ No

If yes, would you like to replace your missing teeth? ☐ Yes ☐ No

Would you like to hear your options for cosmetic dentistry? ☐ Yes ☐ No

Please list any other dental concerns /complaints you may have:

_____

_____

_____

Previous Dentist: _____

Last Visit:_____

MEDICAL HISTORY

Please list all prescription and over-the-counter medications you are taking: _____

_____

Are you allergic to any of the following?

☐ Latex ☐ Penicillin ☐ Penicillin ☐ Dental Anesthetics ☐ Aspirin /Ibuprofen ☐ Tetracycline

Please list any other allergies you have: _____

Have you had any of the following diseases /medical problems?

☐ Artificial Heart Valves
☐ Infective Endocarditis
☐ Cardiac Stents
☐ Cardiac Transplant
☐ Congenital Heart Defect
☐ Heart Attack/Stroke
☐ Heart Surgery/Pacemaker
☐ Heart Failure/Angina
☐ High/Low Blood Pressure
☐ Artificial Joints/Bones
☐ Cancer/Chemotherapy
☐ Radiation Treatment
☐ Taken Osteoporosis Meds
☐ Hemophilia/Abnormal Bleeding
☐ Diabetes
☐ Liver Disease
☐ Drug/Alcohol Abuse
☐ Ulcers/Colitis/Anemia
☐ Tuberculosis
☐ Difficulty Breathing/Asthma
☐ Sinus Problems
☐ Emphysema
☐ HIV/AIDS
☐ Hepatitis
☐ Fainting Spells/Epilepsy/Seizures
☐ Depression
☐ Alzheimer's/Dementia

Please list any other medical condition you have had: _____

_____

Physician's Name: _____

Phone: _____ Date of last visit: _____

Are you currently under the care of a physician? ☐ Yes ☐ No

If yes, explain: _____

WOMEN:

Are you taking birth control pills? ☐ Yes ☐ No Are you pregnant? ☐ Yes, # of weeks: _____ ☐ No Are you nursing? ☐ Yes ☐ No

PATIENT AUTHORIZATION / INSURANCE AUTHORIZATION

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform, with my informed consent, any necessary dental services I may need during diagnosis and treatment.

I hereby authorize my health care provider to affix my name to all insurance submissions, documents, and/or information requested by my insurance company(s) relating to any and all health benefits due to me and my dependants.

I also authorize payment of healthcare benefits otherwise payable to me, directly to my doctor as listed above. I agree to be held responsible for all charges and services not paid by my insurance company and any balance forwarded to an outside collection agency.

Signature _____ Date: _____

Payment is due in full at the time of treatment.

MEDICAL HISTORY UPDATES

DATE	SIGNATURE	COMMENTS