Howell Family Dentist

2765 E. Grand River | Howell, MI 48843 | 517.546.3440
www.howellfamilydentist.com

NEW PATIENT INFORMATION FORM

Title: _____ First Name: _____ MI: _____ Last Name: _____
Birthdate: _____ SSN: _____ Gender: ☐ Male ☐ Female
Address: _____ Apt/Suite: _____
City: _____ State: _____ Zip Code: _____
Phones: Home: _____ Work: _____ Ext: _____
Mobile: _____ Fax: _____ Email: _____
Employer: _____ Phone: _____ Occupation: _____
Referred By: _____ Previous Dentist: _____
Date of last dental exam/cleaning: _____

PERSON RESPONSIBLE FOR ACCOUNT (other than patient)

Title: _____ First Name: _____ MI: _____ Last Name: _____
Relationship to patient: ☐ Self ☐ Spouse ☐ Child ☐ Other _____ SSN: _____
Address: _____ Birthdate: _____
City: _____ State: _____ Zip Code: _____
Phones: Home: _____ Work: _____ Ext: _____
Mobile: _____ Fax: _____ Email: _____
Employer: _____ Phone: _____ Occupation: _____

DENTAL INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Ins. Co.: _____	Ins. Co.: _____
Group: _____ Phone: _____	Group: _____ Phone: _____
Employer: _____	Employer: _____
Employee (if other than patient)	Employee (if other than patient)
Name: _____	Name: _____
Birthdate: _____ SSN: _____	Birthdate: _____ SSN: _____
Subscriber #: _____	Subscriber #: _____
Gender: Male Female	Gender: Male Female

The undersigned consents to dental services and agrees to the release of information for insurance purposes. All co pays and deductibles not covered by insurance will be the responsibility of the account holder.

HOWELL FAMILY DENTIST PATIENT HEALTH HISTORY (Please complete sections 1-6)

SECTION 1

		Yes	No
1.	Are you in good health?	☐	☐
2.	Are you under a physician's care?	☐	☐
3.	Are you subject to prolonged bleeding?	☐	☐
4.	Have you ever had chemotherapy/radiation?	☐	☐
5.	Have you had joint replacement in the last 2 years?	☐	☐
6.	Have you been instructed to take a premed/antibiotic prior to dental treatment due to a heart condition or hip/joint replacement?	☐	☐
7.	Do you have pain or clicking in your jaws/TMJ?	☐	☐
8.	Have you ever been treated for TMJ?	☐	☐

		Yes	No
9.	Have you ever had major surgery?	☐	☐
	List of procedure(s) performed.		
	_____		
	_____		
	_____		
10.	Have you been hospitalized in the last five years?	☐	☐
	List when and the reason or condition.		
	_____		
	_____		
	_____		
11.	**Women Only:**		
	Are you pregnant or think you may be pregnant?	☐	☐
	What month? _____		
	Are you taking birth control?	☐	☐

SECTION 2

	Yes	No
Cancer	☐	☐
Heart condition (pacemaker, angina, etc.)	☐	☐
Heart attack (coronary)	☐	☐
Heart murmur	☐	☐
Rheumatic fever	☐	☐
Diabetes	☐	☐
Arthritis	☐	☐
Hepatitis or liver disease	☐	☐
High blood pressure	☐	☐
Kidney problems	☐	☐
Ulcers	☐	☐
Stroke	☐	☐
Asthma	☐	☐
Respiratory or lung disease	☐	☐
Osteoporosis	☐	☐
Dental anxiety	☐	☐

	Yes	No
Anemia	☐	☐
Epilepsy	☐	☐
Neurological disorders	☐	☐
Glaucoma	☐	☐
Tuberculosis	☐	☐
Blood disorders	☐	☐
HIV positive or AIDS	☐	☐
Sexually transmitted disease	☐	☐
Herpes (oral-cold sores)	☐	☐
Fainting spells	☐	☐
Medical marijuana	☐	☐

Other health problems-please list below:

SECTION 3 Allergies

	Yes	No
Amoxicillin	☐	☐
Penicillin	☐	☐
Dental anesthetic	☐	☐
Novacaine	☐	☐
Aspirin	☐	☐
Codeine	☐	☐
Nitrous oxide	☐	☐
Latex/rubber products	☐	☐
Motrin	☐	☐
Anti-inflammatory	☐	☐
Narcotics	☐	☐

Please list any other allergies:

SECTION 4

LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING. INCLUDE NON-PRESCRIPTION DRUGS (I.E. VITAMINS, HERBAL)

SECTION 5

Medical Doctor's Name:_____

Medical Doctor's Phone Number:_____

SECTION 6

I acknowledge the above health information to be correct and understand any omissions may complicate my care.

Print Name:_____ Date:_____

Patient Signature:_____ Date:_____

Business Staff _____

Clinical Staff _____

Doctor _____