MID-MICHIGAN
PERIODONTICS & DENTAL IMPLANTS

Appointment: ______________
____
____

120 E. Main St.
Bay City, MI 48708
Phone: (989) 892-0440 • Fax: (989) 892-8490

LOCATED IN THE 101 EAST MAIN BUILDING
Parking and entrance is on the backside of the building

WHAT TO EXPECT ON YOUR FIRST VISIT: If you are here in our office with an immediate problem, that will be our first concern. If you are here for consultation to be followed by comprehensive treatment, then we will complete a medical and dental history, an oral examination, and x-rays (if not already provided by your dentist). As a result of these findings, we will arrive at a practical treatment plan for you. At this time, we will also estimate how much the treatment will cost and how long it will take.

OUR CREDIT POLICY: Financial arrangements will be agreed upon prior to the beginning of comprehensive treatment. Dental insurance plans usually do not cover the entire amount of your bill. Your dental coverage is a contract between you and your insurance company, and while we will cooperate fully in filing your claims, you are ultimately responsible for your account.

THE MEDICAL AND DENTAL HISTORY: For your protection we must know the condition of your health before treatment commences. We therefore ask that great care be taken in completing your medical and dental history on the following pages of this form.

REGISTRATION INFORMATION

Name: ______________________________ Date: ____________________

Address: ____________________________ City: __________ State: _____ Zip: ________

Occupation: _________________________ Cell Phone #: ______________________

Telephone #: Home ___________________ Business #:__________________________

Date of Birth: ___________ Age: _______ Social Security #: _______________ Male/Female

Family Dentist: _____________________ Referred by: ________________________

Emergency Contact: __________________ Phone: _______________ Relationship: ________

DENTAL INSURANCE INFORMATION

Member ID or Social Security No. _________________ Insurance Co. ____________________

Employer: ____________________ Member's Name: ____________________ DOB: ________

IF YOU HAVE A SECOND DENTAL PLAN PLEASE COMPLETE THIS SECTION

Member ID or Social Security No. _________________ Insurance Co. ____________________

Employer: ____________________ Member's Name: ____________________ DOB: ________

MEDICAL HISTORY

Are you under a physician's care now?	Y	N	Name: ______________________________
			Address: ____________________________
			Phone: ______________________________
Have you ever been hospitalized or had a major operation	Y	N	Explain: ______________________________
Have you ever had excessive bleeding requiring special treatment?	Y	N	Explain: ______________________________
Have you ever used tobacco products?	Y	N	
Are you currently using tobacco products?	Y	N	

If so, what (cigarettes, chew), how much, and how long? ______________________________

Do you or have you used recreational drugs? ____

Have you ever had a problem with alcohol and/or other substances?	Y	N	Explain: ______________________________
Do you have mental health problems?	Y	N	Explain: ______________________________

When was your last visit to your physician? ____

WOMEN- are you:

Pregnant/Trying to get pregnant?	Y	N
Nursing?	Y	N
Taking birth control?	Y	N

Are you *ALLERGIC* to any of the following?

Aspirin	Y	N	Explain: ____________________________________
Penicillin	Y	N	Explain: ____________________________________
Codeine	Y	N	Explain: ____________________________________
Acrylic	Y	N	Explain: ____________________________________
Metals	Y	N	Explain: ____________________________________
Latex	Y	N	Explain: ____________________________________
Sulfa Drugs	Y	N	Explain: ____________________________________
Local Anesthetics	Y	N	Explain: ____________________________________

Other: ____

Are you taking any *BLOOD THINNER*S? If so, Please circle each one

Plavix/Clopidegrel	Coumadin/Warfarin	Lovanox	Other _________________
Pradaxa/Dabigatran	Eliquis	Effient/Prasugrel	
Brilienta/Ticagrelor	Xarelto/Rivaroxaban	Aspirin/Baby Aspirin	

MEDICATIONS

NAME	DOSAGE	TIMES/DAY

OSTEOPOROSIS HISTORY

Do you take, or have you taken: Phen-fen or Redux? Y N

Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates (treating osteoporosis) Y N

If YES, please provide:

Name, Dosage, Type (IV vs Oral), length of use: ____

Do you have or have you had any of the following:

BREATHING PROBLEMS?

Asthma Y N

Bronchitis Y N

Tuberculosis Y N

Emphysema Y N

Shortness of Breath Y N

Other: ___________________________________

HEART or CIRCULATION PROBLEMS?

Hypertension Y N

Angina or Chest Pain Y N

Rheumatic Fever Y N

Mitral Valve Prolapse Y N

Heart Valve Replacement Y N

Congestive Heart Failure Y N

Other: _____________________________

Heart Attack Y N

If Yes---When ________

Irregular Heart Beat Y N

Heart Murmur Y N

Damage to Heart Valve Y N

Pacemaker Y N

Swollen Ankles Y N

KIDNEY or URINARY PROBLEMS?

Kidney Disease Y N

Frequent Urination Y N

Dialysis Y N

Other: ___________________________________

NERVOUS SYSTEM DISORDERS?

Stroke or transient ischemic attack?	Y	N	Fainting/dizziness spells?	Y	N
Convulsions, seizures, or epilepsy?	Y	N	Other: ____________________		

HEAD and NECK PROBLEMS?

Nose or Sinus problems?	Y	N	Swollen glands?	Y	N
Oral Cancer?	Y	N	Impairment of Hearing?	Y	N
Frequent or severe headaches?	Y	N	Other: ____________________		

HORMONE or GLAND DISORDER PROBLEMS?

Hypothyroidism	Y	N	Diabetes Type I	Y	N
Hyperthyroidism	Y	N	Diabetes Type II	Y	N
Adrenal or Pancreatic disease?	Y	N	Other: ____________________		

MUSCLE, BONE, or SKIN PROBLEMS?

Arthritis	Y	N	Osteoporosis	Y	N
Back Problems	Y	N	Hives or Skin Rash	Y	N
Skin Cancer	Y	N	Other: ____________________		
Artificial Joint	Y	N	Joint/Year: ____________________		

STOMACH, LIVER, or INTESTINAL PROBLEMS?

Liver Disease	Y	N	Hepatitis A, B, or C	Y	N
Acid Reflux (GERD)	Y	N	Ulcers	Y	N

Other: ____________________

BLOOD or IMMUNE SYSTEM PROBLEMS?

Cancer	Y	N	Chemo or Radiation	Y	N
Lupus	Y	N	Multiple Sclerosis	Y	N
Anemia	Y	N	Hemophilia	Y	N
HIV/AIDS	Y	N	Organ or Bone Marrow Replacement	Y	N
Easily bruised or bleeding	Y	N			

COVID-19

Have you had the Covid-19 vaccine? Y N Boosters? Y N

Do you have Covid-19 symptoms? Y N

PRE-MEDICATION

Do you take an antibiotic before dental appointments due to a **joint replacement** or **heart surgery?** Y N If yes, what antibiotic ____________________

DENTAL HISTORY

What is the main reason for your visit?

____

Have you ever had a bad or unusual reaction to local anesthetic? Y N

Have you ever had a severe injury to your face, teeth, or jaws? Y N Explain: ____________________

Have you ever had surgery in your mouth or on your lips? Y N Explain: ____________________

Have you ever had periodontal surgery? Y N Explain: ____________________

Have you ever had braces? Y N

Have you ever had an extraction (pulling) of your tooth or teeth? Y N

Have you ever had endodontics (root canals) on your teeth? Y N

Have you ever had missing teeth replaced by a partial denture (plate), fixed denture (bridge), or implant? Y N Explain: ____________________

Do you have a bitesplint/nightguard? Y N

Have you had a recent toothache or discomfort? Y N Explain: ____________________

Are your teeth hot or cold sensitive? Y N Explain:____________________

Do you have bleeding gums? Y N

Do you have trouble chewing? Y N

Do you clench or grind your teeth? Y N

Do you have difficulty opening your mouth as wide as you would like? Y N Explain:____________________

Do your jaw joints or muscles hurt? Y N Explain:____________________

Does your jaw click, pop, or lock? Y N Explain:____________________

Do you experience dry mouth? Y N

Do you have sores in or around your mouth? Y N Explain:____________________

When was the last time you had your teeth cleaned? ____________________

How often do you brush? ________________

How often do you floss?________________

Are you satisfied with the appearance of your teeth? Y N

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of patient, parent or guardian:

X: ____ **Date:** ______________________