

PATIENT INFORMATION AND HEALTH HISTORY

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Today's Date: _____

ABOUT YOU

Name: _____
I prefer to be called: _____ Male Female
Birthdate: _____ Age: _____
SS #: _____
Driver's License #: _____
Home Address: _____
City: _____ State: _____ Zip: _____
 Single Married Divorced Widowed Separated
Home Phone: _____
Work Phone: _____ Cell: _____
E-mail Address: _____
Employer Name: _____
Emp. Address: _____
City: _____ State: _____ Zip: _____
How long there? _____ Occupation: _____
Where / when are best times to call? _____
Who may we Thank for referring you? _____
Other family members seen by us: _____
Previous / Present Dentist: _____
Last Visit Date: _____

SPOUSE INFORMATION:

Spouse's Name: _____
Employer: _____
Work Phone: _____ Birthdate: _____

PERSON RESPONSIBLE FOR ACCOUNT:

Name: _____
Work Phone: _____
Billing Address: _____
Relationship: _____ SS #: _____
Employer: _____

MEDICAL HISTORY

Do you have a personal physician? No Yes
Physician's Name: _____
Phone: _____ Date of last visit: _____
In the event of an emergency, is there someone who lives near you that we should contact?:
Name: _____ Relation: _____
Work Phone: _____ Home Phone: _____
Your current physical health is: Good Fair Poor
Are you currently under the care of a physician? No Yes
If yes, please explain: _____

DENTAL INSURANCE

PRIMARY DENTAL INSURANCE COMPANY:

Name: _____
Address: _____
City: _____
State: _____
Zip: _____
Phone: _____
Group # (Plan, Local, or Policy#): _____

INSURED PERSON'S INFORMATION:

Name: _____
Birthdate: _____
SS #: _____
Employer: _____
Relationship to Patient: _____

SECONDARY DENTAL INSURANCE COMPANY:

Name: _____
Address: _____
City: _____
State: _____
Zip: _____
Phone: _____
Group # (Plan, Local, or Policy#): _____

INSURED PERSON'S INFORMATION:

Name: _____
Birthdate: _____
SS #: _____
Employer: _____
Relationship to Patient: _____

Are you taking any prescription / over-the-counter drugs?
 No Yes Please list each one: _____

FOR WOMEN:

Are you taking birth control pills? No Yes
Are you pregnant? No Yes
Week #: _____
Are you nursing? No Yes

