Portnoy & Tu DDS PC

1738 Hamilton Rd. Okemos, MI, 48864 • Telephone (517) 349-3266

PATIENT INFORMATION

Today's Date: _____

Name: _____ SSN: _____ Date of Birth: _____ ☐ Male ☐ Female

Home Address: _____ City: _____ Zip: _____

Cell:_____ Work:_____ Phone: _____ Email:_____

Drivers License Number: _____Who can we thank for referring you to our office? _____

Employer Name: _____Employer Address: _____

Person Responsible for Account: _____Address: _____Phone:_____

Emergency Contact Name: _____ Emergency Contact Phone:_____

PRIMARY INSURANCE INFORMATION

Name of Subscriber: _____ Social Security Number: _____ Date of Birth: _____

Name of Employer: _____ Phone Number: _____

Name of Insurance Company: _____ Group or Policy Number: _____

SECONDARY INSURANCE INFORMATION

Name of Subscriber: _____ Social Security Number: _____ Date of Birth: _____

Name of Employer: _____ Phone Number: _____

Name of Insurance Company: _____ Group or Policy Number: _____

MEDICAL HISTORY

Physician's Name: _____ Phone Number: _____

1. Are you under any medical care now? ____ If so, what? _____
2. Are you taking any drugs or medications? ____ If so, what? _____

_____

_____

3. Have you had any major operations? Y / N If yes, what?_____
4. Have you ever had a serious accident involving head injuries? _____
5. Have you ever had ***any adverse or allergic reaction*** to any drugs or materials including (please circle)

Penicillin	Aspirin	Local anesthetics	Iodine	Plastics	Alcohol
Erythromycin	Codeine	Any other antibiotics	Fluoride	Mercury	Latex
Tetracycline	Sulfa drugs	Nitrous oxide	Nickel	Zinc	Other:_____

6. Are you pregnant? Y / N If yes, number of months _____
7. Have you ever taken medication for bone deficiency (Osteoporosis)? Y / N If yes,what?_____
8. Have you ever been on prescription diet (weight loss) medication? Y / N If yes, medication taken _____
9. Do you have night sweats accompanied by weight loss or cough? Y / N How Long? _____
10. Is there anything regarding your Health History that you feel is important that we should know? _____

Have you ever been informed that you had or have any of the following? (please circle)

Y	N	Rheumatic fever	Y	N	Sinus trouble
Y	N	Heart problems (chest pains, angina, heart attack, pacemaker)	Y	N	Respiratory disease (asthma, emphysema, bronchitis, tuberculosis, difficulty breathing)
Y	N	Diabetes	Y	N	Glaucoma
Y	N	Heart murmur	Y	N	Thyroid condition
Y	N	Mitral valve prolapse	Y	N	Kidney disease
Y	N	Blood disease (anemia, leukemia, HIV, AIDS)	Y	N	Ulcers, stomach or intestinal disease
Y	N	Hepatitis (viral A, B, C or D)	Y	N	Hives or skin rash
Y	N	Bleeding / Blood disorder (sickle cell disease)	Y	N	Canker sores or cold sores
Y	N	Cancer	Y	N	Venereal disease (gonorrhea, syphilis or herpes)
Y	N	High / Low blood pressure	Y	N	Immune system disorder
Y	N	Stroke	Y	N	Arthritis or Rheumatism
Y	N	Blood transfusion	Y	N	Disability or handicap mental/physical of any kind
Y	N	Liver disease	Y	N	Epilepsy or Convulsions
Y	N	Radiation or Chemotherapy	Y	N	Fainting History

DENTAL HISTORY

1. Do you have any dental problems or complaints? _____
2. Date of last dental treatment: _____ Dentist's Name: _____
3. Reason for above noted visit: _____
4. Do you have any teeth that are unusually sensitive to any of the following: hot __ cold __ biting __ chewing __ sweets __ Area___
5. Have you ever received professional instructions on brushing, flossing or diet?.....Y / N.....Would you like a review? Y / N
6. Have you ever had a problem with Novocaine or other dental anesthetic? _____
7. Have you ever had any of the following? (please circle)

Orthodontics	Root canal treatment	Crown
Periodontal therapy	Jaw surgery	Removable dentures
Tooth extractions (difficult/ prolonged bleeding/Dry socket)		Fixed bridgework

8. When were your last full mouth X-rays taken? _____
9. Do you now or have you ever smoked? Y / N Currently? Y / N Amount : Daily _____Weekly _____Monthly_____
10. Do you feel that there is anything regarding your Dental History that we should know? _____
11. Please answer the following questions below:

Do you frequently have morning headaches?	Y	N
Do you frequently clench or grind your teeth together?	Y	N
Does your jaw make noise when chewing? Popping/Clicking	Y	N
Do you have pain in or near your ears?	Y	N
Are you fearful about receiving dental treatment?	Y	N
Is your drinking water fluoridated?	Y	N
Have you ever had a problem with Novocain or other dental anesthetic?	Y	N
Do you have unexplained "Sore Spots" in your mouth?	Y	N
Do your gums bleed or do you feel you have "Bad Breath"?	Y	N
Do you chew on only one side of your mouth?	Y	N

As a courtesy, we will process your dental insurance. However,
MOST INSURANCE POLICIES DO NOT COVER ALL DENTAL FEES; THEREFORE, YOU ARE ULTIMATELY RESPONSIBLE FOR ALL FEES INCURRED.

Co-pays are expected at the time of service. A 1.5% finance charge per month will be added for all past due accounts

I have read, understand, and answered the above questions to the best of my knowledge.

Patient's Signature _____ Date _____
(Parent or Guardian if under 18 years of age)

PATIENT'S RESPONSIBILITIES

I understand that I am responsible for and assume full financial responsibility for the dental work I receive as it is rendered. I understand that once the work is started, I authorize Portnoy & Tu DDS PC to release any information necessary to process my dental insurance claims and I authorize payment directly to Portnoy & Tu DDS PC for services rendered. I understand that once dental work has started, I have 30 days to complete this dentistry or the fit is not guaranteed. I am fully responsible for any additional charge to redo this work after 30 days.

Patient's Signature _____ Date _____
(Parent or Guardian if under 18 years of age)