29224 W Eight Mile Rd.
Farmington Hills, MI 48332

Pesis Dental Group, P.C.

Bus: (248) 478-1650
Fax: (248) 478-2166

Cell #_____

Name_____Birthdate_____SS#_____Home #_____

Address_____City_____State_____Zip_____

Occupation_____Employer_____Bus. Phone #_____

Driver's License #_____Email Address_____

Responsible Party_____SS#_____Birthdate_____

Dental Ins._____

Spouse Name_____Birthdate_____SS#_____

Occupation_____Employer_____Bus. Phone #_____

Whom may we thank for referring you?_____

Physician_____Address_____Phone #_____

Are you in good health?_____ If no, explain_____

Do you have an existing illness?_____If yes, explain_____

Have you been hospitalized in the past two years?_____ If so, please list_____

_____

Do you use tobacco products? _____Yes _____ No If yes, explain type and amount_____

Are you taking any medication or over the counter products? _____ If so, please list _____

Are you take any medications for osteoporosis? _____Yes _____No

Are you allergic to: Penicillin_____ Codeine _____ Anesthetics _____ Aspirin _____ Latex _____ Other_____

Do you have frequent, severe headaches? ..... Yes No

Do you have a persistent cough with or without blood? ..... Yes No

Do you have frequent indigestion? ..... Yes No

Do you vomit frequently? ..... Yes No

Do you urinate more than six times a day? ..... Yes No

Are you thirsty much of the time? ..... Yes No

Have you ever had painful and swollen joints? ..... Yes No

Do you have a tendency to faint? ..... Yes No

Do you bruise easily? ..... Yes No

Do you have or have you had any of the following? Please indicate with a check mark.

_____any heart problems	_____aids (HIV)	_____asthma/hay fever
_____rheumatic fever	_____anemia	_____herpes/cold sores
_____abnormal blood pressure	_____diabetes	_____glaucoma
_____nervous problems	_____blood transfusion	_____ kidney problems
_____blood disease	_____heart murmur	_____mitral valve prolapse
_____venereal disease	_____scarlet fever	_____heart surgery (bypass etc..)
_____arthritis	_____radiation treatments	_____circulatory problems
_____epilepsy or seizures	_____stroke	_____TB or Lung disease
_____excessive bleeding	_____hepatitis/jaundice	_____malignancies/cancer
_____ulcers	_____liver disease	_____artificial joint
_____thyroid disease	_____sinus trouble	_____congenital heart lesions

Women: Are you pregnant at the present time?_____If so, what month_____

Name of former dentist_____ Last dental visit_____

Any complications with extractions? Yes _____ No_____

Prolonged bleeding? Yes _____ No_____

Have you ever had a serious problem associated with previous treatment? Yes _____ No_____ If so, explain _____

_____

How often do you brush your teeth?_____ How often do you floss?_____

Do you have difficulty chewing your food or swallowing?	Yes	No
Have you ever had an injury to your face or jaws?	Yes	No
Is it difficult for you to open your mouth as wide as you would like?	Yes	No
Do you clench or grind your jaws while sleeping or during the day?	Yes	No
Do your jaws ever feel tired?	Yes	No
Are your teeth sensitive?	Yes	No
Have you had gum treatments?	Yes	No
Do your gums bleed?	Yes	No
Do you have nasal obstruction?	Yes	No
Any swelling or lumps in your mouth?	Yes	No
Have you had your teeth straightened?	Yes	No
Name of orthodontist	Yes	No

Please describe any medical treatment, impending operations, or any other medical or dental information that may possibly affect your dental treatment:

_____

_____

I have answered the above accurately and completely. I also consent to whatever dental procedures are necessary for the treatment of the above patient and agree to assume full financial responsibility for all treatment rendered.

Signature_____ Date_____

Updates:

_____

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