Dyras Dental, PLLC
Laura J. Dyras, DDS
Michael B. Hutcheson, DDS
601 South Grand Avenue, Lansing, Michigan 48933 | 517.485.1900

Health History Form

Email: _____ Today's Date: _____

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: Last First Middle

_____

Home Phone: Include area code

(_____) _____

Business Cell Phone: Include area code

(_____) _____

Address:

_____

City:

_____

State: Zip:

_____ _____

Occupation:

_____

Height: Weight:

_____ _____

Date of Birth: Sex: M ☐ F ☐

_____

SSN or Patient ID:

_____

Emergency Contact:

_____

Relationship:

_____

Home Phone: include area code

(_____) _____

Cell Phone: Include area code

(_____) _____

If you are completing this form for another person, what is your relationship to that person?

Your Name: _____ Relationship: _____

Insurance Information (patient)

Student: Full Time ☐ Part Time ☐ N/A ☐ School Name/Address: _____

Status: Married ☐ Divorced ☐ Legally Separated ☐ Widow ☐ Single ☐ **Employee:** Full Time ☐ Part Time ☐ Retired ☐ N/A ☐

Do you belong to a PPO or HMO? Yes No

PRIMARY DENTAL INSURANCE COMPANY

Ins. Co. Name: _____

Address: _____

_____ Phone: (_____) _____

Employer: _____

Group #: _____

Subscriber: _____

Subscriber Date of Birth: _____

Subscriber S.S. # or I.D. #: _____

Relationship to patient: _____

SECONDARY DENTAL INSURANCE COMPANY

Ins. Co. Name: _____

Address: _____

_____ Phone: (_____) _____

Employer: _____

Group #: _____

Subscriber: _____

Subscriber Date of Birth: _____

Subscriber S.S. # or I.D. #: _____

Relationship to patient: _____

Dental Information

	Yes	No
Do your gums bleed when you brush or floss?	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐
Is your mouth dry?	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐
Is your home water supply fluorinated?	☐	☐
Do you drink bottled or filtered water?	☐	☐
If yes, how often? DAILY ☐ WEEKLY ☐ OCCASIONALLY ☐		
Are you currently experiencing dental pain or discomfort?	☐	☐

	Yes	No
Do you have earaches or neck pains?	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐
Do you brux or grind your teeth?	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐
Do you wear dentures or partials?	☐	☐
Do you participate in active recreational activities?	☐	☐
Have you ever had serious injury to your head or mouth?	☐	☐

Date of your last dental exam: _____

What was done at that time? _____

Date of last dental x-rays: _____

What is the reason for your dental visit today? _____

How do you feel about your smile? _____

Medical Information

	Yes	No
Are you now under the care of a physician?	☐	☐

Physician Name: Phone: Include area code (_____) _____

Address/City/State/Zip: _____

_____

	Yes	No
Are you in good health?	☐	☐
Has there been any change in your general health in the past year?	☐	☐

If yes, what condition is being treated? _____

Date of last physical exam: _____

	Yes	No
Do you wear contact lenses?	☐	☐
Joint Replacement: Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐

Date: _____

If yes, have you had any complications? _____

	Yes	No
Are you taking or scheduled to begin taking an antiresorptive agent (like Foxaax, Actonel, Atelvia, Boniva, Reclast, Prolia) for osteoporosis or Paget's disease?	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiiresorptive agent (like Aredia, Zometa, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐

Date Treatment began: _____

	Yes	No
Have you had serious illness, operation or been hospitalized in the past 5 years?	☐	☐

If yes, what was the illness or problem? _____

	Yes	No
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

_____

_____

	Yes	No
Do you use controlled substances (drugs)?	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐

How interested are you in stopping? VERY ☐ SOMEWHAT ☐ NOT INTERESTED ☐

	Yes	No
Do you drink alcoholic beverages?	☐	☐

If yes, how much alcohol did you drink the last 24 hours? _____

If yes, how much do you typically drink in a week? _____

	Yes	No
WOMEN ONLY Are you: Pregnant?	☐	☐

Number of weeks: _____

	Yes	No
Taking birth control pills or hormonal replacement?	☐	☐
Nursing?	☐	☐

Are you allergic to or have you had a reaction to: (specify type of reaction)

Local anesthetics _____

Aspirin _____

Penicillin or other antibiotics _____

Barbiturates, sedatives, or sleeping pills _____

Sulfa drugs _____

Codeine or other narcotics _____

Metals _____

Latex (rubber) _____

Iodine _____

Hay fever/seasonal _____

Animals _____

Food _____

Other _____

Medical Information (continued)

	Yes	No
Artificial (prosthetic) heart valve	☐	☐
Previous infective endocarditis	☐	☐
Damaged valves with transplanted heart	☐	☐
Congenital heart disease (CHD)	☐	☐
Unrepaired, cyanotic CHD	☐	☐
Repaired (completely) in last 6 months	☐	☐
Repaired CHD with residual defects	☐	☐
Except for the conditions listed above antibiotic prophylaxis is no longer recommended for any other form of CHD	☐	☐

	Yes	No
Cardiovascular disease	☐	☐
Angina	☐	☐
Arteriosclerosis	☐	☐
Congestive heart failure	☐	☐
Damaged heart vales	☐	☐
Heart attack	☐	☐
Heart murmur	☐	☐
Low blood pressure	☐	☐
High blood pressure	☐	☐
Other congenital heart defects	☐	☐

	Yes	No
Mitral valve prolapse	☐	☐
Pacemaker	☐	☐
Rheumatic fever	☐	☐
Rheumatic heart disease	☐	☐
Abnormal bleeding	☐	☐
Anemia	☐	☐
Blood transfusion	☐	☐
If yes, date: _____		
Hemophilia	☐	☐
AIDS or HIV infection	☐	☐
Arthritis	☐	☐

	Yes	No
Auto immune disease	☐	☐
Rheumatoid arthritis	☐	☐
Systemic lupus erythematous	☐	☐
Asthma	☐	☐
Bronchitis	☐	☐
Emphysema	☐	☐
Sinus trouble	☐	☐
Tuberculosis	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐
Chest pain upon exertion	☐	☐
Chronic pain	☐	☐
Diabetes Type I or II	☐	☐
Eating disorder	☐	☐
Malnutrition	☐	☐
Gastrointestinal disease	☐	☐
G.E. Reflux/persistent heartburn	☐	☐
Ulcers	☐	☐
Thyroid problems	☐	☐
Stroke	☐	☐

	Yes	No
Glaucoma	☐	☐
Hepatitis, jaundice or liver disease	☐	☐
Epilepsy	☐	☐
Fainting spells or seizures	☐	☐
Neurological disorders	☐	☐
If yes, specify: _____		
Sleep disorder	☐	☐
Do you snore?	☐	☐
Mental health disorders	☐	☐
Specify: _____		
Recurrent Infections	☐	☐
Type of infection: _____		
Kidney problems	☐	☐
Night sweats	☐	☐
Osteoporosis	☐	☐
Persistent swollen glands in neck	☐	☐
Severe headaches/migraines	☐	☐
Severe or rapid weight loss	☐	☐
Sexually transmitted disease	☐	☐
Excessive urination	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

Name of physician or dentist making recommendation: _____ Phone: Include area code (_____) _____

Do you have any disease, condition, or problem not listed above that you think I should know about? Please explain:

_____

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

FEES & PAYMENTS

Your insurance policy is a contract between you and your insurance company. Some, and perhaps all, of the services provided may be non-covered services. Your insurance company will determine what benefits are payable once a claim has been submitted. Any co-payment collected from you at the time of service is an estimate of your financial responsibility. You are ultimately responsible for the bill in its entirety. You are required to know the rules and regulations of your insurance carrier and obtain any required referrals or documentation in accordance with those rules. If insurance coverage is not available, payment in full is expected at the time of service. You will be responsible for all collection costs, attorney fees, and court costs. A parent or guardian must accompany anyone 17 or under and will be financially responsible for their account. In the event the parents are divorced, the parent accompanying the minor is financially responsible, regardless of the divorce decree. Settlement must be resolved between parents. Those 18 or older are responsible for their own bill. This signature on file is my acknowledgment that I have read the above policy. I authorize the release of information necessary to process my claim, I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Signature of Patient/Legal Guardian: Date:

_____ _____

Signature of Dentist: Date:

_____ _____