Michael J. O'Connor D.D.S, PC, 53 SB Gratiot, Mount Clemens, MI 48043 (586) 468-5025

Dental Health History

Patient's Name: _____ Today's Date: _____

Reason for today's visit: _____ Date of last dental visit: _____
Previous Dentist: _____ Date of last dental x-rays: _____
Address: _____

Check (√) if you have had problems with any of the following:

- ☐ Bad Breath
- ☐ Grinding Teeth
- ☐ Sensitivity to Hot
- ☐ Bleeding Gums
- ☐ Loose Teeth

- ☐ Sensitivity to Cold
- ☐ Clicking or Popping Jaw
- ☐ Broken Fillings
- ☐ Sensitivity When Biting

- ☐ Food Collection Between Teeth
- ☐ Periodontal Treatment
- ☐ Sores/Growths in Your Mouth

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

Medical Health History

Primary Care Physician's Name _____ Date of Last Visit with Primary Care Physician __/__/__
Have you had any serious illness or operations? ___Yes ___No → if yes, describe _____
Have you ever had a blood transfusion? ___ Yes___No → if yes, give approximate dates __/__/__

(Women) Are you pregnant?___Yes ___No (Women) Nursing?___Yes ___ No
(Women) Taking birth control pills?___Yes ___No

Check (√) if you have or have had any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints, Year of surgery_____
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pace Maker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet
- ☐ Swelling of Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Ulcer
- ☐ Venereal Disease

MEDICATIONS

_____
_____
_____
_____
_____
_____

ALLERGIES

_____
_____
_____
_____
_____

Patient Information

Name: _____ Date: ___/___/_____
Address: _____
City: _____ State: _____ Zip Code: _____
Sex: ___M ___F Birthday: ___/___/_____
Email: _____
Daytime Phone (___) _____
Evening Phone (___) _____
Cell Phone (___) _____
May we contact you via email for appointment reminders?
Yes / No (Please circle one)
Whom can we thank for referring you? _____
In case of an emergency who should we notify? _____ Phone (___) _____

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement

I, _____, have received a copy of this office's Notice or Privacy Practice.
(Patient name or Guardian for minor child)

_____
Please Print Patient's Name

_____ _____
Patient's Signature (or Guardian for minor child) Date

Dental Insurance Information

If no dental insurance, payment is due at time of service

Person responsible for account: _____
Relation to Patient: _____ Birthday ___/___/_____ ID#/SS# _____
Address (if different from patient's): _____ Phone (___) _____
City: _____ State: _____ Zip Code: _____
Person responsible employer name: _____ Business Phone (___) _____
Dental Insurance Company: _____
Group Number: _____ Subscriber Number: _____
Other Dental Insurance: _____ Subscriber Name: _____ Employer: _____
ID#/SS# _____ Birthday ___/___/_____

Dental Insurance Authorization

I certify that I, and/or my dependent(s) have insurance coverage with _____ and assign
Name of Insurance Company
directly to Michael J. O'Connor, D.D.S, PC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, I authorize the use of my signature on all insurance submissions, Michael J. O'Connor, D.D.S, PC may use my health care information and may disclose such information to the above names Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits for the benefits payable for related services.

_____ _____
Signature of Patient, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient