laurichdentistry.com

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248-476-1960

PATIENT MEDICAL HISTORY

Patient Name:______________________________Date______________

Name you prefer to be called___________________________________

Address____

City-State-Zip____

Home Phone#_______________Wk#___________Cell#______________

Birthdate _____________ SSN#_____________________________________

Who referred you_________________your e-mail____________________

Primary Insurance Co_____________Employer________________________

Address & Phone # of Ins Co______________________________________

Name & SSN# of Employee_________________Birthdate of Empl_________

Secondary Insurance Co____________Employer________________________

Address & Phone # of Ins Co______________________________________

Name & SSN# of Employee_________________Birthdate of Empl_________

Physician Name____________________Phone#__________________________

Pharmacy Name____________________Phone#__________________________

Do you smoke? Y N   Women: Are you pregnant? Y N Are you nursing? Y N

Y	N	**Conditions**	Y	N	**Conditions**	Y	N	**Conditions**
☐	☐	Heart Murmur	☐	☐	Drug Abuse/Addiction	☐	☐	Yellow Jaundice
☐	☐	Mitral Valve Prolapse	☐	☐	Emphysema	☐	☐	Alzheimer's Disease
☐	☐	Artificial Valve (Heart)	☐	☐	Epilepsy	☐	☐	Cold Sores/Fever Blisters
☐	☐	Rheumatic Fever	☐	☐	Fainting Spells	☐	☐	Lung Disease
☐	☐	Artificial Joint/Knee/Hip	☐	☐	Frequent Headaches	☐	☐	Hepatitis A,B,C
☐	☐	Congenital Heart Defect	☐	☐	Glaucoma	☐	☐	Bruise Easily
☐	☐	Heart Attack	☐	☐	Hemophilia			
☐	☐	Chest Pain	☐	☐	High Blood Pressure			
☐	☐	Heart Surgery	☐	☐	Low Blood Pressure	Y	N	**Allergies**
☐	☐	Pace Maker	☐	☐	HIV+ AIDS	☐	☐	Aspirin
☐	☐	Abnormal Bleeding	☐	☐	Kidney Problems	☐	☐	Codeine
☐	☐	Anemia	☐	☐	Liver Disease	☐	☐	Dental Anesthetics
☐	☐	Angina Pectoris	☐	☐	Psychiatric Problems	☐	☐	Erythromycin
☐	☐	Arthritis	☐	☐	Radiation Therapy	☐	☐	Jewelry
☐	☐	Asthma	☐	☐	Seizures	☐	☐	Latex
☐	☐	Blood Transfusion	☐	☐	Sickle Cell Disease	☐	☐	Metals
☐	☐	Cancer- Chemotherapy	☐	☐	Sinus Problems	☐	☐	Penicillin
☐	☐	Colitis	☐	☐	Stroke	☐	☐	Tetracycline
☐	☐	Hypoglycemia	☐	☐	Thyroid Problems			**Other**
☐	☐	Diabetes	☐	☐	Tuberculosis			____________________
☐	☐	Difficulty Breathing	☐	☐	Ulcers			____________________
☐	☐	Alcohol Abuse	☐	☐	Venereal Disease			____________________

Medications & reason:

____

____

____

Are there any other medical problems we should be aware of Y N

Describe___________________________________

____

____

Dental History: Reason for visit today________________________

Are you happy with your smile?______Date of last dental visit__________

Would you like your teeth whiter or brighter? ______

Do you have dental exams & cleaning on a regular basis?______________

Do your gums bleed?______Date of last dental xrays________________

Have you ever had a bad experience or are you nervous?______________

I HEARBY AUTHORIZE AND REQUEST THE PERFORMANCE OF DENTAL SERVICES FOR MYSELF OR FOR MY CHILD. I ALSO GIVE MY CONSENT TO ANY ADVISABLE AND NECESSARY DENTAL PROCEDURES, MEDICATIONS OR ANESTHETICS TO BE ADMINISTERED BY THE ATTENDING DENTIST OR BY HIS SUPERVISED STAFF FOR DIAGNOSTIC OR DENTAL TREATMENT.
I AUTHORIZE DR. LAURICH TO TAKE PHOTOS & GRANT THE RIGHT AND LICENSE TO DISPLAY PHOTOGRAPHS OF THE UNDERSIGNED FOR ADVERTISING OR SIMILAR PURPOSES.
I UNDERSTAND AND ACKNOWLEDGE THAT I AM ULTIMATELY FINANCIALLY RESPONSIBLE FOR THE SERVICES PROVIDED FOR MYSELF OR FOR MY CHILD REGARDLESS OF INSURANCE COVERAGE.
(IF APPLIES) I HEARBY AUTHORIZE THE STAFF OF DENNIS LAURICH TO FILE INSURANCE CLAIMS FOR ALL DENTAL WORK PERFORMED AS WELL AS FOR TREATMENT ESTIMATES TO ANY INSURANCE COMPANY COVERING THE ABOVE PATIENT. I AUTHORIZE THE STAFF TO SIGN FOR RELEASE ON INFORMATION AND FOR INSURANCE PAYMENT TO DENNIS LAURICH DDS

SIGNATURE OF RESPONSIBLE PARTY________________________