Novi Oaks Dental
FAMILY & COSMETIC DENTISTRY
- DENTAL SLEEP MEDICINE -

Anjoo C. Ely, DDS
27225 Providence Parkway, Suite 100
Novi, MI 48374
(248) 347-3030

PATIENT HEALTH HISTORY

PATIENT MEDICAL HISTORY

Name:	Date of Birth:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

	YES	NO		YES	NO
1. Are you in good health?			12. Have you ever taken Fen-Phen/Redux?		
2. Have there been any changes in your general health within the past year?			13. Do you use tobacco?		
3. Date of your last physical exam:			14. Do you or have you used controlled substances?		
4. Physician's Name Address Phone			15. Are you wearing contact lenses?		
5. Are you now under the care of a physician?			16. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?		
6. Have you ever been hospitalized for any surgical operation or serious illness? Please explain.			17. Do you have any disease, condition or problem not listed above that you think I should know about?		
7. Are you taking any medicine(s) including non-prescription medicine? If yes, what medicine(s) are you taking?					
8. Have you had any abnormal bleeding?			WOMEN ONLY		
9. Do you bruise easily?			18. Are you pregnant or think you may be pregnant?		
10. Have you ever required a blood transfusion?			19. Are you nursing?		
11. Have you had a recent weight loss?			20. Are you taking birth control pills?		

Are you allergic to or have you had any reactions to:

	YES	NO		YES	NO
Local anesthetics like novocaine			Iodine		
Penicillin or other antibiotics			Any metals (e.g., nickel, mercury, etc.)		
Sulfa drugs			Latex or rubber		
Barbituates, sedatives or sleeping pills			Other (please list)		
Aspirin			Iodine		

Do you have or have you ever had the following:

	YES	NO		YES	NO
Rheumatic heart disease or rheumatic fever			Joint replacement or implant		
Scarlet fever			Stomach ulcer		
Heart defect or heart murmur			Kidney trouble		
Heart trouble, heart attach, or angina			Tuberculosis		

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PATIENT HEALTH HISTORY

Have you ever experienced any of the following problems in your jaw?			Ever worn a bite plate or other appliance		
Clicking			Have you ever had any difficult extractions in the past?		
Pain (joint, ear, side of face)			Have you ever had any prolonged bleeding following extractions?		
Difficulty in opening or closing			Do you wear dentures or partials		
Difficulty in chewing			If yes, date of placement		
Do you have frequent headaches			Have you ever received oral hygiene instructions regarding the care of your teeth and gums?		
If you could change anything about your smile, what would you change?					
SmileChange (Times Roman 9)					

AUTHORIZATION & RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services renedered on my behalf or my dependents.

Signature of patient or parent/guardian if minor.	Date:
Doctor's Comments:	
Signature of doctor.	Date: