Polyviou Family Dentistry
3784 Dix Hwy., Lincoln Park, MI 48146

HEALTH HISTORY

NAME_____BIRTHDATE_____AGE_____

SOC SEC NO._____

HOME ADDRESS _____CITY_____STATE_____ZIP_____

HOME PHONE_____CELL PHONE_____WORK PHONE_____

EMAIL ADDRESS_____

DO YOU HAVE DENTAL INSURANCE? (PLEASE CIRCLE) YES OR NO

IF YES, SUBSCRIBER OF DENTAL INSURANCE_____SOC SEC NO._____

NAME OF DENTAL INSURANCE_____GROUP OR PLAN NO._____

REFERRED BY_____

PERSON FINANCIALLY RESPONSIBLE _____RELATIONSHIP TO YOU_____

SPOUSE NAME_____BIRTHDATE_____

SOC SEC NO._____OCCUPATION_____

EMPLOYER_____PHONE_____

PERSON TO CONTACT IN CASE OF EMERGENCY_____PHONE_____

EMAIL ADDRESS_____

MEDICAL HISTORY

PHYSICIAN_____ADDRESS_____

PHONE_____

ARE YOU IN GOOD HEALTH?_____IF NO, EXPLAIN_____

DO YOU HAVE ANY EXISTING ILLNESS(S)?_____IF YES, EXPLAIN_____

_____

DO YOU BLEED EXCESSIVELY WHEN CUT?_____ DO YOU SMOKE?_____ IF YES, HOW MUCH?_____

ARE YOU TAKING ANY MIEDICATIONS, PILLS, OR DRUGS?_____ IF YES, PLEASE LIST:_____

HEALTH HISTORY

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING? (IF YES, DESCRIBE UNDER "REMARKS" SECTION)
PLEASE CIRCLE --YES OR NO

HEART DISEASE	YES	NO	LIVER DISEASE	YES	NO
HIGH BLOOD PRESSURE	YES	NO	KIDNEY DISEASE	YES	NO
BLOOD DISEASE	YES	NO	HEPATITIS	YES	NO
RHEUMATIC FEVER	YES	NO	ASTHMA	YES	NO
HEART MURMUR	YES	NO	TUBERCULOSIS	YES	NO
DIABETES	YES	NO	AIDS OR HIV POSITIVE	YES	NO
STROKE	YES	NO	ALLERGY TO: (A) PENICLIN (B) OTHER ANTIBIOTICS (C) LOCAL AESTHETICS (D) OTHER	YES YES YES YES	NO NO NO NO
EPILEPSY	YES	NO	ARE YOU PREGNANT	YES	NO
ARTHRITIS	YES	NO	HAVE YOU EVER USED FEN-PHEN	YES	NO
TUMOR HISTORY	YES	NO	DO YOU HAVE HPV? (HUMAN PAPILLOMA VIRUS)	YES	NO
VD	YES	NO	JOINT REPLACEMENTS?	YES	NO
NERVOUS DISORDERS	YES	NO	CANCER (IF YES, WHAT TYPE?) _____ ARE YOU IN TREATMENT?	YES YES	NO NO
RADIATION TREATMENT	YES	NO	PERIODONTAL (GUM) DISEASE	YES	NO

IS THERE A FAMILY (PARENT, GRANDPARENT, SIBLING) HISTORY OF THE ABOVE? IF SO, WHAT? _____

_____

DENTAL HISTORY

DO YOU HAVE ANY PRESENT DENTAL COMPLAINTS? (PLEASE CIRCLE) YES OR NO

IF YES, WHAT?_____

WHEN WAS YOUR LAST FULL MOUTH X-RAY TAKEN?_____WHERE?_____

WHEN WAS YOU RLAST CLEANING?_____WHERE?_____

HAVE YOU EVER BEEN INSTRUCTED IN THE PREVENTION OF DECAY?_____

HAVE YOU EVER BEEN INSTRUCTED IN CARING FOR YOUR GUMS?_____

HAVE YOU EVER BEEN TREATED FOR OR TOLD YOU HAVE PERIODONTAL, GUM DISEASE, OR BONE LOSS?_____

REMARKS_____

I CONSENT TO WAHTSOEVER DENTAL PROCEDURES AND ANESTHETICS THAT ARE NECSESSARY FOR THE TREATMENT OF THE ABOVE NAMED PATIENT. I AGREE TO ASSUME FULL FINANICAL RESPONSIBILITY FOR ALL TREATMENT RENDERED.

SIGNATURE_____**DATE**_____

Oral Health Risk Factors

Patient's Name_____

1. Do you smoke or have you EVER smoked?
   (If No, proceed to question 2)
   The amount that you are presently smoking (check ALL that apply)
___None (quit smoking completely) __Less than 1 pack of cigarettes per day __An occasional cigar
___An occasional cigarette __1-2 packs of cigarettes per day __Cigars on a daily / regular basis
___A few cigarettes per day __2 or more packs of cigarettes per day __A pipe on daily / regular basis
If you have quit smoking, when did you quit?
__Less than 6 months ago __6 months to a year ago __1-3 years ago __Over 3 years ago
How many years have you or did you smoke?
__Less than 2 years __2-5 years __5-10 years __10-20 years __Over 20 year

2. Do you / Have you EVER chew / chewed tobacco or use / used snuff or other similar substance? Yes No
   (If No, proceed to question 3)
   Are you STILL using smokeless tobacco or snuff?
   If No, WHEN did you quit?
   __Less than 6 months ago __6 months to a year ago __1-3 years ago
   How many years did you see or have you used smokeless tobacco?
   __Less than 1 year __1-2 years __2-5 years __Over 5 years

3. Approximate average amount of alcoholic beverages presently consumed per week:
   __None __Less than 1 per week __1-5 drinks __6-11 drinks __11-20 drinks __Over 20 drinks
4. Do you have or have you ever had a substance abuse problem? Yes No
   Describe_____

5. Do you presently use any recreational drugs? Yes No
   List_____

6. Do you have or have you ever had an eating disorder? Yes No
   If yes, please specify:_____

7. Do you have or have you ever had any head, neck or mouth piercing(s)? (Other than ears) Yes No
   List_____

8. Do you have or have you ever been informed that you have been infected with an oncogenic strain (possible cancer-causing) of the Human Papillomavirus (HPV?) Yes No

9. Please list your history or any family member's history of cancer:_____
_____

10. Other concerns and considerations:_____
_____

CONSENT- To the best of my knowledge, all of the preceding information is correct and if there is every any change in health, or medications, this practice will be informed of the changes without fail. I also consent to allow this practice to contact any healthcare providers and to have ht patient's health information released to aid in care and treatment. I also hereby consent to allow diagnosis, proper health care and treatment to be performed by this practice for the above named individual until further notice.

I understand there are no guarantees or warranties in health or dental care.
Signature_____ Date_____
Reviewed By:_____

PERMISSION FOR DENTAL TREATMENT

I consent to the performance of dental procedures to be discussed with and explained by the doctors and employees of Paul M. Polyviou D.D.S., P.C. and other procedures, which may be deemed necessary and advisable.

PATIENT OR LEGAL GUARDIAN_____DATE_____

RELEASE OF RECORDS AND ASSIGNMENT OF BENEFITS

I hereby authorize Paul M. Polivou D.D.S., P.C. to release any information regarding the dental history, treatment or benefits payable for dental claims to the Dental Plan Administrator or its authorized agent for the purpose of validating and determining benefits payable in connection with dental claims.

I further authorize payment directly to Paul M. Polyviou D.D.S., P.C. of dental benefits otherwise payable to me.

PATIENT OR LEGAL GUARDIAN_____ DATE_____

SIGNATURE ON FILE

I authorize the use of standardized forms for all my dental insurance submissions and I permit my signature on file to be used in place of the original.

PATIENT OR LEGAL GUARDIAN_____DATE_____

FUTURE RELEASE OF RECORDS

I authorize Paul M. Polyviou, D.D.S., P.C. to release the medical/dental records of

_____ to _____

PATIENT OR LEGAL GUARDIAN_____ DATE_____