RYAN BREASBOIS D.D.S. P.C.

1455 N. Michigan Ave, Suite 800
Howell, MI 48843

Patient Health History Update Form

Patient Information:

Today's Date: ____/____/____ Name:_____

☐ Single ☐ Married ☐ Widowed D.O.B:_____/_____/_____ Age: _____

Home Address: _____
Street *City* *State* *Zip*

Home Phone:(_____)_____-_____ Cell Phone:(___)____-_____ Work Phone:(___)_____-____

Patient Emergency Contact:

Their Name:_____ Relationship To You:_____

Phone Number: (____)_____-_____ Place Of Work:_____

Insurance Information:

Has your insurance changed since your last visit?_____

** If you answered yes please provide your updated information:*

_____ _____ _____-_____-_____ ____/____/____
Insurance CO. Name *Group Number* *Insured's Social Security* *Insured's D.O.B*

For the following questions please circle "Y" for Yes and "N" for No

Dental History:

Do you take a premedication for dental treatment Y /N - *What do you take?:*_____
Do you experience pain/discomfort in your jaw joint? Y / N
Do you wear a Bite Splint?: Y / N

For Women:

Are you taking Birth control? Y / N Are you pregnant? Y / N Are you nursing? Y / N

Medications:

List Any Medications You Are Taking Here:

_____

If you are taking multiple please attach separate list

Medical History:

Do you have a personal physician? Y / N *If answered "Yes" complete the following*

Physician's Name:_____ Phone Number:(____)_____-_____

Address:_____

Street *City* *State* *Zip*

Have you ever taken Fosamax or any other Bisphosphonate? Y / N

If *"Yes"*, when did you start:_____ and are you still currently taking it:_____

Do you smoke or use tobacco in any form? Y / N *If "Yes" what form*:_____

Are you allergic to the following?

Y / N Aspirin	Y / N Latex	Y / N Jewelry	Y / N Tetracycline
Y / N Dental Anesthetics	Y / N Sedatives	Y / N Codeine	Y / N Penicillin
Y / N Sulfa Drugs	Y / N *Other Please List*:_____		

Are You taking any of the following?

Y / N Acetaminophen	Y / N Blood Pressure Medication	Y / N Recreational Drugs
Y / N Antibiotics	Y / N Cold remedies	Y / N Steroids/ Cortisone
Y / N Antihistamines	Y / N Digitalis/ Heart Meds	Y / N Thyroid Medicine
Y / N Aspirin	Y / N Insulin/ Diabetes Meds	Y / N Tranquilizers
Y / N Blood thinners	Y / N Nitroglycerin	Y / N Other: _____

Do you have or experienced the following?

Y / N Abnormal Bleeding	Y / N Alcohol Abuse	Y / N Anemia	Y / N Arthritis
Y / N Asthma	Y / N Artificial Bones/Joints	Y / N Artificial Valves	Y / N Blood Transfusion
Y / N Cancer	Y / N Chemotherapy	Y / N Chicken Pox	Y / N Colitis
Y / N Congenital Heart Defect	Y / N Diabetes	Y / N Difficulty Breathing	Y / N Drug Abuse
Y / N Emphysema	Y / N Epilepsy	Y / N Fainting Spells	Y / N Fever Blisters
Y / N Glaucoma	Y / N Hay Fever	Y / N Headaches	Y / N Heart Attack
Y / N Heart Murmur	Y / N Heart Surgery	Y / N Hemophilia	Y / N Hepatitis
Y / N Herpes	Y / N High Blood Pressure	Y / N HIV/AIDS	Y / N Kidney Problems
Y / N Liver Disease	Y / N Low Blood Pressure	Y / N Lupus	Y / N Mitral Valve Prolapse
Y / N Pacemaker	Y / N Persistent Cough	Y / N Psychiatric Problem	Y / N Radiation Treatment
Y / N Rheumatic Fever	Y / N Scarlet Fever	Y / N Seizures	Y / N Shingles
Y / N Sickle Cell Disease	Y / N Venereal Disease	Other:_____	

I affirm that the information I have provided is correct to the best of my knowledge. It will Be held in the strictest confidence and it is my responsibility to inform the office if there are any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

Signature:_____ Date: ___/___/___