



609 W. South St. / Mason MI 48854

Patient: _____

Today's Date: _____

Date Last Completed: _____

PATIENT INFORMATION

First Name: _____ Last Name: _____

Birth Date: _____ Gender: ☐ Male ☐ Female

Address: _____

Email: _____ Cell Phone: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other

Emergency Contact: _____ Phone: _____

Preferred Pharmacy: _____

INSURANCE INFORMATION

- ☐ No Insurance Changes
- ☐ No Dental Insurance
- ☐ Single Dental Insurance
- ☐ Dual Dental Insurance

Primary Insurance

Name of Insurance Company: _____ State: _____

Policy Holder Name: _____ Birth Date: _____

Member ID: _____ Group: _____

Name of Employer: _____

Relationship to Insurance holder: ☐ Self ☐ Parent ☐ Child ☐ Spouse ☐ Other _____

MEDICAL HISTORY

Please list all medications you are currently taking and the correlating diagnosis :



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Please list all known allergies:

Please list all operation/hospitalizations within the last 5 years:

Please check all that apply

- | | | | |
|--|---|--|--|
| ☐ Anemia | ☐ Congenital Heart Lesions | ☐ Hepatitis | ☐ Scarlet Fever |
| ☐ Arthritis | ☐ Cortisone Treatment | ☐ Hernia Repair | ☐ Shortness of Breath |
| ☐ Artificial Heart Valve | ☐ Cough - Persistent | ☐ High Blood Pressure | ☐ Skin Rash |
| ☐ Artificial Joints, Pins, etc. | ☐ Cough up Blood | ☐ HIV/AIDS | ☐ Stroke |
| ☐ Asthma | ☐ Diabetes | ☐ Jaw Pain | ☐ Swelling of Feet/Ankles |
| ☐ Back Problems | ☐ Epilepsy | ☐ Kidney Disease | ☐ Thyroid Problems |
| ☐ Bleeding Abnormally | ☐ Fainting | ☐ Liver Disease | ☐ Tobacco Use |
| ☐ Blood Disease | ☐ Glaucoma | ☐ Mitral Valve Prolapse | ☐ Tonsillitis |
| ☐ Cancer | ☐ Headaches | ☐ Pacemaker | ☐ Tuberculosis |
| ☐ Chemical Dependency | ☐ Heart Murmur | ☐ Radiation Treatment | ☐ Ulcer |
| ☐ Chemotherapy | ☐ Heart Problems | ☐ Respiratory Disease | ☐ Venereal Disease |
| ☐ Circulatory Problems | ☐ Hemophilia | ☐ Rheumatic Fever | |

Are you pregnant? ☐ Yes ☐ No

Are you currently nursing? ☐ Yes ☐ No

Do you smoke or use tobacco? ☐ Yes ☐ No

AUTHORIZATION & RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature

Date