

# LEVAN DENTAL GROUP PLC

## HEALTH HISTORY

PATIENT NAME: \_\_\_\_\_ D/O/B: \_\_\_\_\_

NAME OF PHYSICIAN: \_\_\_\_\_ PHYSICIAN'S PHONE: \_\_\_\_\_

HOW LONG SINCE YOUR LAST DENTAL VISIT: \_\_\_\_\_

ARE YOU IN GOOD HEALTH?      YES      NO      ARE YOU CURRENTLY UNDER MEDICATION?      YES      NO  
                 

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN?      YES      NO      IF SO, PLEASE LIST: \_\_\_\_\_  
     

IF YES, FOR WHAT CONDITION? \_\_\_\_\_

DO YOU WEAR A PARTIAL OR FULL DENTURE?      YES      NO  
     

IF YES? HOW OLD IS IT? \_\_\_\_\_

HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING? (PLEASE CHECK YES OR NO)

DO YOU USE TOBACCO PRODUCTS	Yes <input type="checkbox"/>	NO <input type="checkbox"/>	ARE YOU PREGNANT/NURSING?	Yes <input type="checkbox"/>	NO <input type="checkbox"/>
DO YOU WANT TO STOP USING TOBACCO PRODUCTS?	<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULOSIS (TB)	<input type="checkbox"/>	<input type="checkbox"/>
RHEUMATIC FEVER	<input type="checkbox"/>	<input type="checkbox"/>	EPILEPSY	<input type="checkbox"/>	<input type="checkbox"/>
HEART MURMUR	<input type="checkbox"/>	<input type="checkbox"/>	ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>
OTHER HEART PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	DIABETES	<input type="checkbox"/>	<input type="checkbox"/>
ARTIFICIAL JOINTS, PINS OR RODS	<input type="checkbox"/>	<input type="checkbox"/>	FAINING	<input type="checkbox"/>	<input type="checkbox"/>
HEPATITIS	<input type="checkbox"/>	<input type="checkbox"/>	EXCESSIVE BLEEDING	<input type="checkbox"/>	<input type="checkbox"/>
VENEREAL DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	NERVOUS DISORDERS	<input type="checkbox"/>	<input type="checkbox"/>
COLD SORES	<input type="checkbox"/>	<input type="checkbox"/>	CHRONIC HEADACHES	<input type="checkbox"/>	<input type="checkbox"/>
SWOLLEN OR BLEEDING GUMS	<input type="checkbox"/>	<input type="checkbox"/>	HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>
TMJ SYNDROME	<input type="checkbox"/>	<input type="checkbox"/>	OTHER (PLEASE EXPLAIN) _____		

ARE YOU ALLERGIC OR SENSITIVE TO ANY MEDICATION? (FOR EXAMPLE PENICILLIN, SULFA, LATEX, ETC)

PLEASE LIST: \_\_\_\_\_

CHIEF DENTAL COMPLAINT: \_\_\_\_\_

THE POLICY IN OUR OFFICE IS: The patient who requests Treatment for the child is responsible for all fees for specific services.

SIGNATURE; CONSENT TO TREATMENT: \_\_\_\_\_ DATE: \_\_\_\_\_  
(PATIENT, PARENT OR GUARDIAN SIGNATURE FOR MINOR CHILD OR PATIENT)

I have reviewed my medical history and the above (including any changes) is accurate:

Date: \_\_\_\_\_ Initials: \_\_\_\_\_      Date: \_\_\_\_\_ Initials: \_\_\_\_\_      Date: \_\_\_\_\_ Initials: \_\_\_\_\_

Date: \_\_\_\_\_ Initials: \_\_\_\_\_      Date: \_\_\_\_\_ Initials: \_\_\_\_\_      Date: \_\_\_\_\_ Initials: \_\_\_\_\_

Date: \_\_\_\_\_ Initials: \_\_\_\_\_      Date: \_\_\_\_\_ Initials: \_\_\_\_\_      Date: \_\_\_\_\_ Initials: \_\_\_\_\_

### LEVAN DENTAL GROUP PLC

15406 LEVAN RD.  
LIVONIA, MI 48154

The following information is confidential. It is requested in order to supply complete dental care. Please supply accurate answers.

PATIENT NAME: \_\_\_\_\_

PARENT / GUARDIAN : \_\_\_\_\_

SPOUSE NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

CITY: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_

CELLULAR/PAGER: \_\_\_\_\_

DRIVER LICENSE #: \_\_\_\_\_

DRIVER LICENSE #: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_

CELLULAR / PAGER: \_\_\_\_\_

EMAIL: \_\_\_\_\_

<u>DEPENDANT'S NAME</u>	<u>DEPENDANT'S D/O/B</u>
1. _____	____/____/____
2. _____	____/____/____
3. _____	____/____/____
4. _____	____/____/____

PREFERRED CONTACT NUMBER: (CHECK ONE)

Home

Work

Cellular/Pager

NAME OF PERSONS RESPONSIBLE FOR ACCOUNTS: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

HOW DID YOU HEAR ABOUT OUR PRACTICE? \_\_\_\_\_

WHOM MAY WE CONTACT IN CASE OF EMERGENCY? (Other than household member)

NAME: \_\_\_\_\_ ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

DO YOU HAVE DENTAL INSURANCE?  YES  NO

COMPANY/CARRIER: \_\_\_\_\_

SUBSCRIBERS NAME: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_

SUBSCRIBER'S EMPLOYER: \_\_\_\_\_

EMPLOYERS ADDRESS: \_\_\_\_\_

I accept responsibility for all fees that are not covered by my dental and/or medical insurance company.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

(Parent or Guardian signature if patient is a minor or has an appointed guardian)



## Appointment Policy for Levan Dental Group

We want our patients to know how much we value your business. In an effort to provide the highest quality dentistry at affordable prices, **we request 48 hours notice** for any schedule changes that you may need in the future. Our office understands that sometimes emergency situations arise and we will handle each circumstance on an individual basis. We would like our patients to understand that missed or broken appointments are hurtful in many ways. First, they delay your treatment and our ability to keep your oral health at optimum levels. Second, they may prevent another patient who needs treatment from getting the necessary care in a timely manner. In order for us to provide you with high quality dentistry, we must reduce the amount of missed appointments and no-shows. With this in mind we want you to be informed of our appointment policy so there are no misunderstandings in the future.

**All patients are required to call the office back to verbally confirm their appointment time or your appointment may be forfeited. Each patient may miss two appointments due to emergency without 48 hours notice in an 18 month period. If a 3<sup>rd</sup> broken appointment occurs we will not re-appoint you for any future appointments without a credit card. Should you miss this appointment, your credit card will be charged \$50 for a hygiene appointment and \$75 for an appointment with Dr Abdelnour. A 4<sup>th</sup> missed appointment will result in your dismissal from our practice. We will be glad to forward your records to a dentist whose hours better fit your schedule.**

Thank you for your cooperation. We remain committed to your oral health.

Patient Name(print): \_\_\_\_\_

Signature of Patient or Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**Levan Dental Group 15406 Levan Rd Livonia, MI 48154 734-464-8020**