NEWBURYPORT Dental Associates PC est. 1978

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Today's Date: _____

HEALTH HISTORY FORM

PATIENT INFORMATION

Name: _____

I prefer to be called: _____

❑ M ❑ F Date of Birth: _____ / _____ / _____ Age: _____

Home Address: _____

_____

Occupation: _____

Employer: _____

Contact Information *(check primary #)*:

❑ Home: _____

❑ Cell: _____

❑ Work: _____

Email: _____

Whom may we thank for referring you?

_____

Marital Status *(check one)*:

❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Spouse/Partner's Information:

Name: _____

Occupation: _____

Phone Number: _____

DENTAL INSURANCE

Primary Insurance:

Subscriber Name: _____

Date of Birth: _____ / _____ / _____ Relationship: _____

Address *(if different from patient)*: _____

_____

Employer Name: _____

Insurance Company: _____

Group #: _____

Subscriber ID #: _____

Social Security Number: _____

Secondary Insurance:

Subscriber name: _____

Date of Birth: _____ / _____ / _____ Relationship: _____

Address *(if different from patient)*: _____

_____

Employer name: _____

Insurance Company: _____

Group #: _____

Subscriber ID #: _____

PLEASE NOTIFY FRONT DESK
IF THERE IS ANY ADDITIONAL COVERAGE

EMERGENCY CONTACT INFORMATION

❑ Check if same as Spouse/Partner above

Name: _____ Relationship: _____ Phone #: _____

DENTAL HISTORY

Please mark (X) your responses to the following questions:	Yes	No
Do your gums bleed when you brush or floss?	❑	❑
Are your teeth sensitive to cold, hot, sweets or pressure?	❑	❑
Is your mouth dry?	❑	❑
Have you had any periodontal (gum) treatments?	❑	❑
Have you ever had orthodontic (braces) treatments?	❑	❑
Have you had any problems associated with previous dental treatment?	❑	❑
Are you currently experiencing any pain or discomfort?	❑	❑
Do you have any clicking, popping or discomfort in the jaw?	❑	❑
Do you grind or clench your teeth?	❑	❑
Have you ever had a serious injury to your head or mouth?	❑	❑
Do you have dental anxiety?	❑	❑

What is the reason for your visit today?

_____

_____

How do you feel about your smile?

_____

_____

Date of your last dental exam:

_____

Date of last dental x-rays:

_____

Patient Name: _____ **Date of Birth:** _____ / _____ / _____

MEDICAL INFORMATION

Are you now under the care of a physician? ❑ Yes ❑ No

Physician's name: _____ Phone number: _____

Date of last physical exam: _____

Have you had a serious illness, operation, or been hospitalized in the past 5 years? ❑ Yes ❑ No

If yes, what was the illness or problem? _____

Has a physician or previous dentist recommended you take antibiotics prior to your dental treatment? ❑ Yes ❑ No

If yes, for what reason? _____

Please indicate if you have had any of the following *(check all that apply)*:

- ❑ **Orthopedic Total Replacement** (hip, knee, elbow, shoulder, finger) Date of procedure: _____
- ❑ **Artificial Heart Valves**
- ❑ **Congenital Heart Disease**
- ❑ **Previous Infective Endocarditis**
- ❑ Cardiovascular Disease
- ❑ Angina
- ❑ Arteriosclerosis
- ❑ Chest Pain upon exertion
- ❑ Congestive Heart Failure
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Mitral Valve Prolapse
- ❑ Pacemaker
- ❑ Rheumatic Heart Disease
- ❑ Abnormal Bleeding
- ❑ Anemia
- ❑ Hemophilia
- ❑ AIDS or HIV Infection
- ❑ Arthritis
- ❑ Rheumatoid Arthritis
- ❑ Systemic Lupus Erythematosus
- ❑ Asthma
- ❑ Bronchitis
- ❑ Emphysema
- ❑ Sinus Trouble
- ❑ Tuberculosis
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Radiation Treatment
- ❑ Chronic Pain
- ❑ Diabetes: ❑ Type I ❑ Type II
- ❑ Gastrointestinal Disease
- ❑ Ulcers
- ❑ Thyroid Problems
- ❑ Stroke
- ❑ Glaucoma
- ❑ Hepatitis or Liver Disease
- ❑ Epilepsy
- ❑ Fainting Spells or Seizures
- ❑ Kidney Problems
- ❑ Osteoporosis
- ❑ Severe Headaches / Migraines
- ❑ Snoring
- ❑ Sleep Apnea
- ❑ Hearing Loss
- ❑ Neurological Disorder If yes, please specify: _____
- ❑ Mental Health Disorder If yes, please specify: _____
- ❑ Limited Mobility If yes, please specify: _____
- ❑ Wheelchair

Do you have any disease, condition, or problem not listed above that you think we should know about? ❑ Yes ❑ No

Please explain: _____

Are you taking or scheduled to take either of these medications: Alendronate (Fosamax®) or Risedronate (Actonel®)? ❑ Yes ❑ No

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates, Aledia® or Zometa®r? ❑ Yes ❑ No Date treatment began: _____

Do you use tobacco (cigarettes, snuff, chew, bidis)? ❑ Yes ❑ No If yes, please specify: _____

How much per day? _____

WOMEN: Are you pregnant? ❑ Yes ❑ No / Nursing? ❑ Yes ❑ No / Taking oral contraceptives? ❑ Yes ❑ No

MEDICATIONS

Are you taking or have you recently taken any prescription or over-the-counter medicine(s)? ❑ Yes ❑ No

If yes, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

_____

_____

ALLERGIES

Are you allergic to any of the following? *(check all that apply)*

- ❑ Aspirin
- ❑ Barbiturates (sleeping pills)
- ❑ Codeine
- ❑ Iodine
- ❑ Latex
- ❑ Local Anesthetic
- ❑ Penicillin
- ❑ Sulfa
- ❑ NSAIDS
- ❑ Tylenol (Acetaminophen)
- ❑ Food *(please specify)*: _____
- ❑ Other *(please specify)*: _____

Patient or legal guardian signature: _____ Date: _____ / _____ / _____

Dentist signature: _____ Date: _____ / _____ / _____