

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?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure?	<input type="checkbox"/>	<input type="checkbox"/>
Is your mouth dry?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any periodontal (gum) treatments?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had orthodontic (braces) treatments?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any problems associated with previous dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently experiencing any pain or discomfort?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any clicking, popping or discomfort in the jaw?	<input type="checkbox"/>	<input type="checkbox"/>
Do you grind or clench your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a serious injury to your head or mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have dental anxiety?	<input type="checkbox"/>	<input type="checkbox"/>

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*):

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

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®? 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*)

- | | | | |
|--|---|-------------------------------------|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Iodine | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Tylenol (Acetaminophen) |
| <input type="checkbox"/> Barbiturates (sleeping pills) | <input type="checkbox"/> Latex | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Food (<i>please specify</i>): _____ |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> NSAIDS | <input type="checkbox"/> Other (<i>please specify</i>): _____ |

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

Dentist signature: _____ Date: ____ / ____ / ____