

Patient Information & Health History Form (PLEASE PRINT LEGIBLY)

Patient's Last Name _____ First _____ Middle _____ DATE _____
Address _____ City _____ State _____ Zip _____
Home Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____
Email Address _____ Social Security # _____ Age _____ Date of Birth _____
Sex: M F Marital Status: Single Married Widowed Divorced Partnered Minor
If a Full Time Student, Name of College & City _____
Has any member of your family been seen in our office? Yes No If Yes, Name _____ Relationship _____
Family Name for Billing Purposes (Main Account Holder's Last Name) _____
Billing Address, If Different From Above _____
Do you have Dental Insurance? Yes No If Yes, please complete Dental Insurance Information Form
Patient's (Or Parent's) Employer _____ Work Phone, If Different from Above (_____) _____
Position _____
Employer's Address _____ City _____ State _____ Zip _____
Spouse's Name _____ Spouse's Social Security # _____
Spouse's Employer _____ Spouse's Work Phone (_____) _____
Emergency Contact _____ Phone (_____) _____
If referred to our office, by whom? (Name of Person, Family Member, Dentist, Yellow Pages, Etc.) _____

DENTAL INFORMATION

Reason for today's visit _____ Date of last dental exam _____
Former Dentist _____ Phone (_____) _____ Date of last dental X-rays _____
How often do you brush? _____ How often do you floss? _____
Describe your current dental problem, if any: _____
Any serious problem/difficulties in your dental history? _____

Check all that apply:

- | | | |
|---|---|--|
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Past orthodontics (braces) treatment | <input type="checkbox"/> Clicking or popping jaw |
| <input type="checkbox"/> Periodontal (gum) treatment | <input type="checkbox"/> Currently wear removable appliance | <input type="checkbox"/> Food collection between teeth |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Sores or growths in your mouth | <input type="checkbox"/> Grinding teeth |
| <input type="checkbox"/> Sensitivity to hot/cold/sweet/pressure | <input type="checkbox"/> Loose or broken teeth | <input type="checkbox"/> Earaches or neck pains |

MEDICAL INFORMATION

Physician's Name _____ Phone (_____) _____ Date of last physical exam _____
Are you in good health? _____ Any health changes in the past year? _____
Are you currently being treated/under a doctor's care? _____ If so, for what condition? _____
Any serious illness/operation/hospitalization in the past 5 years? _____ If so, for what condition? _____
Do you premedicate with antibiotics before dental treatments? _____ If so, which antibiotic? _____

Are you allergic to, or ever had a reaction to any of the following? Yes No If Yes, check all that apply:

- | | | |
|--|--|---|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa drugs | <input type="checkbox"/> Other allergies: _____ |
| <input type="checkbox"/> Local anesthetics | <input type="checkbox"/> Codeine or other narcotics | _____ |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Iodine | _____ |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Metals (specify) _____ | _____ |
| <input type="checkbox"/> Barbituates, sedatives, sleeping aids | <input type="checkbox"/> Antibiotics (specify) _____ | _____ |

Women Only:

Are you, or could you be pregnant? _____ Nursing? _____ Taking birth control pills or hormone replacement? _____

(PLEASE TURN OVER TO COMPLETE FORM)

MEDICAL INFORMATION (Continued)

Are you taking, or recently have taken any medications, including prescription drugs and recreational drugs, or injections? _____

If so, list: _____

Have you ever taken Fosamax? _____ Have you ever taken any diet drugs such as Phen-fen? _____

Do you use tobacco (smoking, snuff, chew)? _____ Are you taking blood thinners? _____

Check all that apply if you've had or have any of the following:

- | | | |
|--|---|--|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Excessive Urination | <input type="checkbox"/> Radiation Treatment, Chemotherapy |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting, Seizures | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Gastrointestinal Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> G.E. Reflux/Persistent Heartburn | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Asthma, Emphysema, Lung Disorders | <input type="checkbox"/> Headaches, Migraines | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Blood Disease, Blood Transfusion | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Systemic Lupus Erythematosus |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Swollen Feet or Ankles |
| <input type="checkbox"/> Chest Pain Upon Exertion | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Swollen Glands in Neck |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Infections, Recurrent | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Dry Mouth | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Osteoporosis | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pacemaker | |
|
 | | |
| <input type="checkbox"/> Cardio Vascular Disease | | |
| If checked, which of the following apply?: | | |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Damaged Heart Valves | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Congenital Heart Defects | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Congenital Heart Failure | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic Heart Disease |

Please explain any other health concerns (disease, condition, or problem) not listed above: _____

AUTHORIZATION & RELEASE

To the best of my knowledge, the information on this form is complete and correct. I understand that it is my responsibility to inform this office if I, or my minor child, have a change in health. Even if no information has changed, this form must be updated every 5 years.

This dental office may use this health care information, and disclose such information to my insurance company and their agents for the purpose of obtaining payment for services and for determining insurance benefits or the benefits payable for related services.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

PATIENT, PARENT OR LEGAL GUARDIAN

Copayments are due in full at the time of treatment unless prior arrangements have been approved