|  |
| --- |
|  |
| **Health History Form** |
| **Patient Information** |
| Name: | Preferred name: |
| LASTAddress: | FIRST  | MIDDLE INITIAL City: | State:  | Zip Code: |
| P.O. BOX or Mailing Address Home Phone: ( ) | Cell Phone: ( ) | Email: |
| DOB:  | Relationship status: Single / Married / Partnered / Divorced / Separated / Widowed |
| Occupation: | Employer: | Employer Phone: ( ) |
| SS no.:  | Emergency Contact: | Relationship: |  Phone: ( ) |
|  If you are completing this form for another person, what is your relationship to that person? |
| Chose office because / Referred to office by (***as much detail as possible would be greatly appreciated***): |
| Other family members seen here: |

|  |
| --- |
| **Insurance Information** |
| Please give your insurance card to the receptionist and fill out the following information to the best of your ability. This will help us determine insurance coverage that may be applied to this visit. If the subscriber information is the same as above, you may leave this section blank. |

|  |  |
| --- | --- |
| Person responsible for the bill: | Relationship to patient: |
| LAST Home Phone: ( ) | FIRST | MIDDLE INITIALCell Phone: ( ) |
| Address: | City: | State:  | Zip Code: |
| P.O. BOX or Mailing Address Email: | Occupation: | Employer: |
| Is this person a patient here? ❑ Yes ❑ No | Patient’s primary dental insurance: |
| Insurance subscriber’s name: | Subscriber’s S.S. no.: | Birth date: |
| LAST Patient’s relationship to subscriber: |  FIRSTIns. group no.: | Policy no.: | Co-payment: $ |

For the following questions, please (X) whichever applies, your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide optimal care for you. This office does not use this information to discriminate.

|  |
| --- |
| **Dental Information** |

|  |
| --- |
| What is the reason for your visit today? |
| Do you have any additional dental concerns? |
| How do you feel about the appearance of your teeth? |
| What would you like to learn more about? |
| Date of last dental visit: | What was done at that time? |
| Date of last dental cleaning (if different): |  |  | **Yes No DK** |
| Date of last full mouth x-rays (if different): |  | Have you had any periodontal (gum) treatments? | ❑ ❑ ❑ |
| How often do you brush your teeth? |  | Are your teeth sensitive to cold, hot, sweets or pressure? | ❑ ❑ ❑ |
| Generally, how often do you floss? |  | Have you ever had orthodontic treatment? | ❑ ❑ ❑ |
| Do your gums bleed when you brush? |  | Do you have earaches or neck pains? | ❑ ❑ ❑ |

|  |  |  |  |
| --- | --- | --- | --- |
| **Have you experienced:** | **Yes No DK** | Do you clench or grind your teeth while awake or asleep? | ❑ ❑ ❑ |
| Clicking or popping of the jaw? | ❑ ❑ ❑ | Do you wear removable dental appliances? | ❑ ❑ ❑ |
| Difficulty in opening or closing the mouth? | ❑ ❑ ❑ | Do you mouth breath while awake or asleep? | ❑ ❑ ❑ |
| Difficulty in chewing on either side of the mouth? | ❑ ❑ ❑ | Do you have tired jaws, especially in the morning? | ❑ ❑ ❑ |
| Headaches, neck aches or shoulder aches? | ❑ ❑ ❑ | Do you snore or have any other sleeping disorder? | ❑ ❑ ❑ |

|  |
| --- |
|  **Medical Information** |
| **If you answer yes to any of the 3 items below, please stop and return** **This form to the receptionist.** | Date of last physical examination: |  |
| Have you had any of the following diseases or problems? | **Yes No DK** | Physician: |  |
| Active Tuberculosis | ❑ ❑ ❑ | ( ) | NAME |
| Persistent cough greater than a 3-week duration | ❑ ❑ ❑ |  PHONE | ADDRESS |
| Cough that produces blood | ❑ ❑ ❑ | CITY/STATE | ZIP **Yes No DK** |
| Are you in good health? | ❑ ❑ ❑ | **In the past 5 years have you experienced any of the following situations?** |
| In the past year, has there been any change in your general health? | ❑ ❑ ❑ | Serious illness, operation, or been hospitalized | ❑ ❑ ❑ |
| Are you now under the care of a physician? | ❑ ❑ ❑ | If yes, what was the illness or problem? |  |
| If yes, what is/are the condition(s) being treated? Please explain below. |  |  |
|  | Have you had an orthopedic total joint replacement? | ❑ ❑ ❑ |
| Are you taking, or have you recently taken, any medication(s) including | If yes, what was the date of the surgery? |  |
| non-prescription medications? | ❑ ❑ ❑ | Has a physician or previous dentist recommended that you take antibiotics |
| If yes, please list any prescribed medication(s): | prior to your dental treatment? | ❑ ❑ ❑ |
|  |  | If yes, what antibiotic and dose? |  |
| Do you use tobacco (smoking, snuff, chew)? | ❑ ❑ ❑ | Name of physician or dentist (if different from above): |
| If yes, how interested are you in stopping? |  |
| Do you drink alcoholic beverages? | ❑ ❑ ❑ | Phone: ( ) |

|  |  |
| --- | --- |
| **Are you allergic to or have you had a reaction to any of the following items?** | **Women Only** |
| Local anesthetics | ❑ ❑ ❑ | Please answer the following to the best of your knowledge. |  |
| Aspirin | ❑ ❑ ❑ | Are you or could you be pregnant? | ❑ ❑ ❑ |
| Penicillin or other antibiotics | ❑ ❑ ❑ | Nursing? | ❑ ❑ ❑ |
| Barbiturates, sedatives, or sleeping pills | ❑ ❑ ❑ | Taking birth control pills or hormonal replacement? | ❑ ❑ ❑ |
| Sulfa drugs | ❑ ❑ ❑ |  |  |
| Codeine or other narcotics | ❑ ❑ ❑ | **Allergies continued.** |
| Latex | ❑ ❑ ❑ | To any yes allergy responses, please specify type of reaction. |
| Iodine | ❑ ❑ ❑ |  |

|  |
| --- |
| **Please (X) a response to indicate if you have or have not had any of the following diseases or problems.** |
| Abnormal bleeding | ❑ ❑ ❑ | Hemophilia | ❑ ❑ ❑ |
| AIDS or HIV infection | ❑ ❑ ❑ | Hepatitis, jaundice or liver disease | ❑ ❑ ❑ |
| Anemia | ❑ ❑ ❑ | Mental health disorders | ❑ ❑ ❑ |
| Arthritis or Rheumatoid arthritis | ❑ ❑ ❑ | If yes, specify: |
| Asthma | ❑ ❑ ❑ | Malnutrition | ❑ ❑ ❑ |
| Blood transfusion. If yes, date:  | ❑ ❑ ❑ | Neurological disorders | ❑ ❑ ❑ |
| Cancer/Chemotherapy/Radiation Treatment | ❑ ❑ ❑ | If yes, specify:  |
| Chronic pain | ❑ ❑ ❑ | Night sweats | ❑ ❑ ❑ |
| Chest pain upon exertion | ❑ ❑ ❑ | Osteoporosis | ❑ ❑ ❑ |
| Diabetes. If yes, specify: | ❑ ❑ ❑ | Persistent swollen glands in neck | ❑ ❑ ❑ |
| Disease, drug, or radiation-induced immunosuppression | ❑ ❑ ❑ | Respiratory problems. | ❑ ❑ ❑ |
| Dry Mouth | ❑ ❑ ❑ | If yes, please specify: Emphysema, Bronchitis, etc. | ❑ ❑ ❑ |
| Eating disorder. If yes, specify: | ❑ ❑ ❑ | Severe headaches/migraines | ❑ ❑ ❑ |
| Epilepsy | ❑ ❑ ❑ | Severe or rapid weight loss | ❑ ❑ ❑ |
| Fainting spells or seizures | ❑ ❑ ❑ | Sexually transmitted disease | ❑ ❑ ❑ |
| Gastrointestinal disease | ❑ ❑ ❑ | Sinus trouble | ❑ ❑ ❑ |
| G.E. Reflux/persistent heartburn  | ❑ ❑ ❑ | Sleep disorder | ❑ ❑ ❑ |
| Glaucoma | ❑ ❑ ❑ | Sores or ulcers in the mouth | ❑ ❑ ❑ |
| Recurrent Infections  | ❑ ❑ ❑ | Stroke | ❑ ❑ ❑ |
| Kidney problems | ❑ ❑ ❑ | Systemic lupus erythematosus | ❑ ❑ ❑ |
| Cardiovascular disease. | ❑ ❑ ❑ | Tuberculosis | ❑ ❑ ❑ |
| If yes, specify: | Thyroid problems | ❑ ❑ ❑ |

NOTE: Both Doctor and patient are encouraged to discuss all relevant patient health issues prior to treatment. I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| SIGNATURE OF PATIENT/LEGAL GUARDIAN |  | DATE |