Health History Form

Today's Date: _____/_____/_____

We are pleased to welcome you to our practice. Please take a few moments to fill out this form as completely as you can. As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to all applicable laws.

Name _____(_____) SSN _____-_____-_____
Last Name First Name Middle Initial Preferred Name

Sex: ☐M ☐F ☐Single ☐Married ☐Divorced ☐Separated Birthdate _____/_____/_____

Address _____
City State Zip

Email _____ Home # (_____)_____ Cell # (_____)_____

Patient's Employer _____ *Work # (_____)_____
*Provide only if we have permission to call you at work

Emergency Contact _____ Relationship _____ Cell # (_____)_____

****How did you hear about our office? _____**

Responsible Party (If different than above)

Name _____(_____) SSN _____-_____-_____
Last Name First Name Initial Preferred

Sex: ☐M ☐F ☐ Single ☐Married ☐Divorced ☐Separated Birthdate _____/_____/_____

Address _____
City State Zip

Email _____ Home # (_____)_____ Cell # (_____)_____

Spouse's Information

Name _____(_____) SSN _____-_____-_____
Last Name First Name Initial Preferred

Birthdate _____/_____/_____ Cell # (_____)_____ Work # (_____)_____

Spouse's Employer _____

Primary Insurance

Subscriber Name _____ Relationship to Patient _____
Last Name First Name

Insurance Co _____ Phone # (_____)_____

Group # _____ Subscriber ID# _____

Secondary Insurance

Subscriber Name _____ Relationship to Patient _____
Last Name First Name

Insurance Co _____ Phone # (_____)_____

Group # _____ Subscriber ID# _____

Assignment of Insurance: I authorize the release of all medical information necessary to process my claims and I authorize the release of this same information, when necessary, to other providers rendering medical/dental care.

Signed _____ Date _____

Dental History

What is the reason for your dental visit today? _____

Date of your last dental exam: _____ Former Dentist: _____

How do you feel about your smile? _____

Please mark your responses to the following questions.

Yes	No		Yes	No	
☐	☐	Bleeding gums	☐	☐	Home water supply fluoridated
☐	☐	Sensitive to hot, cold, or pressure	☐	☐	Earaches or neck pain
☐	☐	Food collection between teeth	☐	☐	Clicking, popping or discomfort in jaw
☐	☐	Dry mouth	☐	☐	Brux (Grind) your teeth
☐	☐	Periodontal (Gum) treatment	☐	☐	Sores or ulcers in your mouth
☐	☐	Orthodontic (Braces) treatment	☐	☐	Serious injury to your head or mouth

Any problems associated with previous dental treatment: ☐ **Yes** ☐ **No** (If Yes, please explain below)

_____

Medical History

Physician's Name _____ Phone _____

Date of last exam _____ Have you had any serious illness or operations? ☐ **Yes** ☐ **No**

If yes, please explain _____

Women, Are you: Pregnant ☐ **Yes** ☐ **No** Number of weeks: _____ Nursing ☐ **Yes** ☐ **No**
Taking birth control pills or hormonal replacement ☐ **Yes** ☐ **No**

Allergies - Are you allergic to or have you had a reaction to: (To all **Yes** responses, specify type of reaction)

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Aspirin	☐	☐	Local anesthetics	☐	☐	Penicillin or antibiotics	☐	☐	Latex
☐	☐	Iodine	☐	☐	Sulfa drugs	☐	☐	Barbiturates or sedatives	☐	☐	Other
☐	☐	Metals	☐	☐	Seasonal/Animals	☐	☐	Codeine or other narcotics			

Please indicate whether you have had any of the following:

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	AIDS/HIV Positive	☐	☐	Chemotherapy	☐	☐	Hemophilia/Abnormal bleeding	☐	☐	Radiation treatment
☐	☐	Anemia	☐	☐	Cortisone treatment				☐	☐	Recurrent Infections
☐	☐	Angina	☐	☐	Diabetes: Type I or II	☐	☐	Hepatitis A__ B__ C__	☐	☐	Respiratory disease
☐	☐	Arthritis	☐	☐	Epilepsy	☐	☐	Herpes/Mouth Sores	☐	☐	Rheumatic/Scarlet fever
☐	☐	Artificial heart valves	☐	☐	Fainting	☐	☐	High blood pressure	☐	☐	Stroke
☐	☐	Artificial joints	☐	☐	G.E Reflux/persistent heartburn	☐	☐	Kidney disease	☐	☐	Surgical implant
☐	☐	Asthma				☐	☐	Liver disease	☐	☐	Tetracycline Stain
☐	☐	Back problems	☐	☐	Headaches	☐	☐	Mitral valve prolapse	☐	☐	Tobacco habit
☐	☐	Blood thinners	☐	☐	Heart murmur	☐	☐	Pacemaker/Heart surgery	☐	☐	Thyroid Disease
☐	☐	Cancer	☐	☐	Heart problems	☐	☐	Psychiatric care	☐	☐	Tuberculosis

Has a physician/previous dentist recommended that you take antibiotics PRIOR to your dental treatment? ☐ **Yes** ☐ **No**

Name of physician/dentist making recommendation: _____

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

List of medications: _____

_____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. I certify that I have read and understand the previous statement, and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for my treatment. 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. After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgment of the doctor may decide in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

Signed _____ **Date** _____