WELCOME TO OUR PRACTICE

TODAY'S DATE _____/_____/_____

Patient Name _____

Address _____

_____

City/State/Zip _____

Birthdate ____/____/_____ Age _____ Sex____

S.S.# _____

Single ___ Married___ Divorced ___ Widowed ___ Separated___

Employer _____

Occupation _____

How long at current job? _____

Spouse Name _____

Spouse employer _____

How long at current job? _____

Spouse work phone _____

CONTACT INFORMATION (circle the one which you want us to use):

Home phone _____

Work phone _____

Cell phone _____

Text message _____

Email address _____

COMPLETE IF RESPONSIBLE PARTY IS OTHER THAN PATIENT:

Relationship to patient _____

Name _____

Address _____

City/State/Zip _____

Phone (_____) _____

DENTAL INSURANCE

Insurance Company _____ Address _____

City/State/Zip _____ Phone (_____) _____

Insured's employer _____ Insured's name _____

Insured's S.S. _____ Relationship to patient _____

Policy number _____ Insured's birthdate _____/_____/_____

MEDICAL INSURANCE

Insurance Company _____ Address _____

City/State/Zip _____ Phone (_____) _____

Insured's employer _____ Insured's name _____

Insured's S.S. _____ Relationship to patient _____

Policy number _____ Insured's birthdate _____/_____/_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

_____

Name_____

Date:_____

Patient Health History

1. Please describe the main reason you are seeking dental care? _____

_____

2. Are you currently under the care of a physician? _____Yes ❒ No ❒

3. Have you had any serious illness, hospitalization, or surgery? _____Yes ❒ No ❒
   If yes, please describe: _____

4. Have you taken corticosteriods within the last year?
   (i.e. Prednisone, Medrol, Dexamethasone)_____Yes ❒ No ❒

5. Have you ever taken Bisphosphonates (osteoporosis medication) by mouth or IV?
   (i.e. Boniva, Fosamax, Actonel) _____Yes ❒ No ❒

6. Are you currently taking blood thinners?
   (i.e. Coumadin, Warfarin, Plavix, Aspirin) _____Yes ❒ No ❒

7. Do you have an allergy to Latex? _____Yes ❒ No ❒

8. Have you ever had a joint replacement surgery or been instructed by a physician to take antibiotics
   before dental treatment? _____Yes ❒ No ❒

9. Do you have any history of substance abuse or alcohol dependence? _____Yes ❒ No ❒

10. Do you smoke or use tobacco in any other form? _____Yes ❒ No ❒

11. (Please check all that apply)
    I am: Pregnant ❒ Planning pregnancy ❒ Taking birth control pills ❒
    If pregnant, how many weeks? _____

12. Please list all prescription and over-the-counter medications you are currently taking:

    _____

    _____

13. Do you have any medication allergies or have you had a bad reaction to a medication?____ Yes ❒ No ❒
    What type of medication?
    Sulfa Drugs ❒ Penicillin ❒ Codeine ❒ Hydrocodone ❒ Aspirin ❒
    Other ❒ _____If yes, please describe the type of reaction you experienced:

    _____

14. How do you feel about the appearance of your teeth? (Please explain)

_____

15. Are you aware of any snoring or have you been diagnosed with sleep apnea? _____Yes ❒ No ❒

(If yes, please explain) _____

16. Do you have or have you ever had any of the following? (Please check yes or no)

Heart Disease

YES	NO	
❒	❒	High Blood Pressure
❒	❒	Chest Pain/Angina
❒	❒	Heart Attack
❒	❒	Rheumatic Heart Disease
❒	❒	Congenital Heart Defect
❒	❒	Congestive Heart Failure
❒	❒	Heart Murmur or Palpitations
❒	❒	Heart Valve Replacedment
❒	❒	Pacemaker Installed
❒	❒	Other Heart Surgery

Lung Disease

YES	NO	
❒	❒	Shortness of Breath
❒	❒	Asthma
❒	❒	Chronic Bronchitis
❒	❒	Emphysema
❒	❒	Pneumonia
❒	❒	Tuberculosis
❒	❒	Persistent Cough

Blood-related Condition

YES	NO	
❒	❒	Prolonged Bleeding
❒	❒	Anemia
❒	❒	Sickle Cell Disease
❒	❒	Blood Transfusion
❒	❒	HIV/AIDS
❒	❒	Hepatitis A
❒	❒	Hepatitis B
❒	❒	Hepatitis C
❒	❒	Jaundice
❒	❒	Other Bleeding Disorder

Other Condition

YES	NO	
❒	❒	Stroke
❒	❒	Diabetes
❒	❒	Epilepsy/Seizures
❒	❒	Fainting
❒	❒	Dizziness
❒	❒	Moderate to Severe Anxiety
❒	❒	Depression
❒	❒	Psychiatric Disorder
❒	❒	Hypothyroidism
❒	❒	Hyperthyroidism
❒	❒	Arthritis
❒	❒	Glaucoma
❒	❒	Nervous System Disorders
❒	❒	Hormone Disorders
❒	❒	Digestive/Intestinal Disorders
❒	❒	Cancer
❒	❒	Radiation Treatment
❒	❒	TMJ Disorders
❒	❒	Teeth Grinding or Clenching
❒	❒	Recurring Infections
❒	❒	Sinus/Nasal Problems
❒	❒	Seasonal Allergies
❒	❒	Chronic Nasal Congestion
❒	❒	Other Health Condition Not Listed
		Please describe: _____

Treatment Authorization and Acknowledgement

I consent to dental treatment as necessary or desirable for the care of my oral health. Procedures will be discussed and explained to the patient before they take place. In addition to the procedures themselves, I give my consent for the taking of dental radiographs, the use of local anesthetic and/or nitrous oxide. I have filled out this health history to the best of my ability, and I understand and agree to this treatment authorization.

Patient/Guardian's Signature _____ **Date** _____

Doctor's Signature_____ **Date** _____