Health History

(Confidential)

Please complete front and back of form

Today's Date: ______________________

General Information

Name: ____
Last First MI

Male ________ Female ________ Prefered Noun __________ Other ______________

Address: ____
Street/PO City State Zip

Home phone ______________________ Email ______________________

Cell Phone ______________________ Drivers License # ______________________

Date of Birth ______________________ Emergency contact Name ______________ Phone# __________

SSN ______________________ Physicians Name ______________ Phone# __________

Work Phone ______________ EXTN: ________

Person Responsible for Account if other than yourself

Name: ______________ Relation ______________ Home Phone# ______________ Work Phone# ______________

Address: ____
Street/PO City State Zip

Insurance Information: Yes No If yes please show your new card to a front office member.

Primary Insurance		Secondary Insurance	
Employer		Employer	
Insurance Company Name		Insurance Company Name	
Phone#		Phone#	
Group#		Group#	
Insureds Name		Insureds Name	
ID/SSN		ID/SSN	
Birthdate		Birthdate	
Relation		Relation	

Dental History

Question			
Are you currently in dental pain?	Y	N	If yes, where ______
Are your teeth sensitive to heat, sold, sweets, pressure from biting or chewing?	Y	N	If yes, where ______
Have you experienced problems associated with any previous dental work?	Y	N	If yes, where ______
Have you ever been told you have gum disease?	Y	N	
Have you ever been treated for gum disease?	Y	N	
Do you require antibiotics prior to dental treatment?	Y	N	
Do you still have your wisdom teeth?	Y	N	
Have you had braces?	Y	N	
Do you have frequent cold sores, canker sores, fever blisters on your gums, cheeks, lips?	Y	N	

Do you or have you had any of the following

Condition			Condition		
Chronic neckaches/Headaches	Y	N	Pain or ringing in your ears	Y	N
Tooth mobility or looseness	Y	N	Unpleasant taste or bad breath	Y	N
Grinding or clenching of teeth	Y	N	Jaw muscles tire stiff or painful	Y	N
Bleeding or sore gums	Y	N	Clicking, popping, difficulty opening or closing jaw	Y	N
Food catching in your teeth	Y	N			

Have there been any changes in your health in the past two years? Y N If "Y" please list changes.

______________________ ______________________

List all prescribed and any over the counter medications

____

Do you have or have you had any of the following medical conditions

Condition	Y	N	Condition	Y	N
Angina/chest Pain	Y	N	Arthritis	Y	N
Artificial Heart Valve	Y	N	Artificial Joints	Y	N
Congestive Heart Failure	Y	N	Asthma	Y	N
Fainting/Dizziness	Y	N	Auto Immune Disease	Y	N
Heart Surgery/Heart Attack	Y	N	Chronic Cough	Y	N
High Blood Pressure	Y	N	Emphysema	Y	N
Kidney Disease	Y	N	HIV positive (AIDS)	Y	N
Miral Valve Prolase	Y	N	Seizures/Epilepsy	Y	N
Heart Murmur	Y	N	Thyroid Disease/Goiter	Y	N
Pacemaker	Y	N	Tuberculosis	Y	N
Rheumatic Fever	Y	N	Tumors	Y	N
Seasonal Allergies	Y	N	Phychiatric treatment	Y	N
Shortness of Breath	Y	N	Stomach Ulcers	Y	N
Stroke	Y	N	Bleeding/Clotting Disorder	Y	N
Anemia	Y	N	Sinus Nasal problems	Y	N
Detached Retina/Eye Disorder	Y	N	Liver Disease, Jaundice	Y	N
MRSA	Y	N	Hepatitis Type: ______		

GERD (Gastro Esophageal Reflux Disorder) Y N

Sleep Apnea (use of CPAP machine) Y N

Are you taking or have you ever taken medication for Bone Density? Y N

Cancer Treatment Y N

Date of Diagnosis ______________________

Type ______________________

Treatment ______________________

Diabetes Y N

Have you or are you taking GLP1 medication? Y N

Type ______________________

Dosage ______________________

Duration ______________________

Are you allergic to any of the following?

Allergen	Y	N	Allergen	Y	N
Penicillin	Y	N	Local Anesthetic	Y	N
Codeine	Y	N	Sedatives	Y	N
Sulfa	Y	N	Aspirin	Y	N
Latex	Y	N	Ibuprofen	Y	N
Iodine	Y	N	Shellfish	Y	N

Please list any other allergies or items you have a reaction to:

____

____

Women

Are you taking Birth Control? Y N

If yes what type:

Pills _____ Norplant _____

Shots _____

Patch _____ Other __________

Are you taking hormone replacements (HRT)? Y N

Are you pregnant or think you may be? Y N

Due Date: __________

Are you nursing? Y N

Chemical Dependency

Smoking Y N How much? How long? ______________________

Chewing tobacco Y N How much? How long? ______________________

History of alcohol or drug dependency Y N

Marijuana Y N

Type: edible smoking

Frequency: Daily Weekly Sporadic

Amount: __________

With regards to oral contraceptives it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my family or me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand I am responsible for paying all services rendered at Dental Health PC. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I am aware there are no service fees for 60 days; after which the interest rate is 18% annually. I am aware of the $50.00 missed appointment fee.

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Patient name (please Print) Signature of Patient or Parent if Minor Date