Patient Health History:

Please fill out pages 1–4.
Please initial & date each page.

Name ❑Mr. ❑Mrs. ❑Ms. _____ Age _____ Birthdate _____

Address _____

City/State/Zip _____

Phone _____ Social Security # _____

Cell Phone _____ Email _____

Employed By _____ Occupation _____

Business Address _____

City/State/Zip _____ Bus. Phone _____

Person Responsible For This Account _____ Self Employed ❑Yes ❑No

Address For Billing _____

City/State/Zip _____

Closest relative or friend to be called if unable to reach you. ❑Friend ❑Relative

Name _____ Phone _____

Address _____

City/State/Zip _____

Referred By _____

Notes:

FINE DENTAL

2 Medical History:

Physician's Name _____ Phone _____

Office Address _____

City/State/Zip _____

Are you at present or have recently been under the care of a physician? ❑No ❑Yes If yes, reason for treatment ____

_____

Is your general health? ❑Good ❑Poor Have you ever been hospitalized? ❑No ❑Yes If yes, WHY? _____

_____

When did you have your last medical check up? Date_____ Are you pregnant? ❑No ❑Yes If yes, what month _____

Are you taking any medicines, drugs or pills at the present? ❑No ❑Yes If yes, please explain _____

_____

Have you ever had an injury to your face or jaw? ❑No ❑Yes If yes, explain _____

Is there any other special information that should be known about your health? ❑No ❑Yes If yes, explain _____

_____

Height_____ Weight_____

Have you ever been told by a physician that you have or had any of the following conditions?

❑No ❑Yes High Blood Pressure
❑No ❑Yes Low Blood Pressure
❑No ❑Yes Heart Disease
❑No ❑Yes Rheumatic Fever
❑No ❑Yes Blood Disease
❑No ❑Yes Anemia or Blood Problems
❑No ❑Yes Diabetes
❑No ❑Yes Hepatitis or Liver Problems
❑No ❑Yes Stroke
❑No ❑Yes HIV

❑No ❑Yes Venereal Disease
❑No ❑Yes Tuberculosis
❑No ❑Yes Cancer
❑No ❑Yes Kidney Disease
❑No ❑Yes Mumps
❑No ❑Yes Arthritis
❑No ❑Yes Ulcers or Colitis
❑No ❑Yes Nervous Stomach
❑No ❑Yes Thyroid

❑No ❑Yes Glandular Problem
❑No ❑Yes Respiratory Disease
❑No ❑Yes Asthma
❑No ❑Yes Sinus Trouble
❑No ❑Yes Convulsions or Fits
❑No ❑Yes Epilepsy
❑No ❑Yes Nervous Disorder
❑No ❑Yes Emotional Difficulty
❑No ❑Yes Allergies, Hay Fever

Are you allergic to:

❑No ❑Yes Penicillin
❑No ❑Yes Novocaine
❑No ❑Yes Bufferin
❑No ❑Yes Sulfa
❑No ❑Yes Tranquilizers

❑No ❑Yes Any Antibiotic
❑No ❑Yes Aspirin
❑No ❑Yes Codeine
❑No ❑Yes Cortisone
❑No ❑Yes Darvon

Are you subject to:

❑No ❑Yes Headaches
❑No ❑Yes Dizziness
❑No ❑Yes Fainting
❑No ❑Yes Cold Hands
❑No ❑Yes Bruise Easily

❑No ❑Yes Nervousness
❑No ❑Yes Shortness of Breath
❑No ❑Yes Prolonged Bleeding
❑No ❑Yes Difficulty in Healing When Cut

Any Others Which Are Not Listed _____

_____

Describe any current medical treatment including drugs taken, even though not listed above _____

_____

_____

_____

Patient, please initial and date each page. Initial **X** _____ Date _____

Dental History:

Have you noticed:

❑No ❑Yes Change in Color of Gums
❑No ❑Yes Bleeding Gums
❑No ❑Yes Swollen Gums
❑No ❑Yes Bad Mouth Odor or Taste
❑No ❑Yes Teeth Tender to Chew On
❑No ❑Yes Teeth Sensitive to Hot or Cold
❑No ❑Yes Unusual Sounds in Ear While Eating
❑No ❑Yes Pain Around Ear

❑No ❑Yes Teeth Sensitive to Sweets
❑No ❑Yes Change in Color of Teeth
❑No ❑Yes Spaces Developing Between Teeth
❑No ❑Yes Food Catching Between Teeth
❑No ❑Yes Swelling or Lump in Mouth
❑No ❑Yes Change in Appearance of Face
❑No ❑Yes Burning of Tongue
❑No ❑Yes Frequent Blisters on Lips or Mouth

Are you now experiencing pain from your mouth? For how long? _____

When did you last visit a dentist? _____

Reason for changing dentist? _____

When did you last have your teeth cleaned? _____

Do you or have you ever worn a denture or partials? _____

Are you aware of clenching or grinding your teeth? _____

Have you ever had treatment for a tumor or growth in or around your mouth? _____

_____

Are you satisfied with the appearance of your smile? _____ If no, why? _____

_____

Are you missing any teeth? _____

If you could change anything about your teeth, what would it be? _____

_____

APPOINTMENTS: A minimum charge will be made for failed or cancelled appointments without prior notification of 24 hours. This fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved for you.

INSURANCE: To avoid misunderstandings regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies, upon receipt of full (or partial) payment of bill. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient.

Patient's Signature **X** _____ Date _____

4 Circle Problems:

Please indicate areas where you feel you are having–or may be having–problems by circling the appropriate words. Also, please describe any other symptoms or disorders, and give us any pertinent information not previously covered:

_____

_____