Czaplicki Family Dentistry

PLEASE FILL OUT THIS HEALTH HISTORY FORM ***ENTIRELY***
THANK YOU!

Name: _____ Date: _____

Primary Doctor's Name: _____ Date of Last Visit: _____

Have you ever used Bisphosphonate medication? Common brands are Fosamax, Actonel, Atelvia, Didronel, Boniva. Yes No

Are you required to take **Pre-Medication**? Yes No Have you **ever** had any serious illnesses or operations? Yes No

If yes, please describe: _____

(**Women**) Are you pregnant? Yes No Nursing? Yes No Taking Birth Control Pills? Yes No

Check (✓) if you have or have had any of the following:

☐Anemia	☐Cortisone Treatments	☐Hepatitis	☐Scarlet Fever
☐Arthritis, Rheumatism	☐Cough, Persistent	☐High Blood Pressure	☐Shortness of Breath
☐Artificial Heart Valves	☐Cough up Blood	☐HIV/AIDS	☐Skin Rash
☐Artificial Joints	☐Diabetes	☐Jaw Pain	☐Stroke
☐Asthma	☐Epilepsy	☐Kidney Disease	☐Swelling of feet/ankles
☐Back Problems	☐Fainting	☐Liver Disease	☐Thyroid Problems
☐Blood Disease	☐Glaucoma	☐Mitral Valve Prolapse	☐Tobacco Habit
☐Cancer	☐Headaches	☐Pacemaker	☐Tonsillitis
☐Chemical Dependency	☐Heart Murmur	☐Respiratory Disease	☐Ulcer
☐Circulatory Problems	☐Hemophilia	☐Rheumatic Fever	☐Venereal Disease

List ALL MEDICATIONS you are taking:

_____
_____
_____
_____

List ALL ALLERGIES you have:

_____
_____
_____
_____

Cell Phone #: _____ Email: _____

(*IF NEW*) Address: _____

(*IF NEW*) Insurance Company: _____ ID #: _____ Group #: _____

I certify that I, and/or my dependents(s), have insurance coverage with _____ and assign directly to Czaplicki Family Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.

I, _____, acknowledge receipt of a copy of the currently effective Notice of Privacy Practices for Czaplicki Family Dentistry. Czaplicki Family Dentistry may use my healthcare information and may disclose such information to the above-named insurance company(ies) and their agents for purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date above. A copy of this signed document shall be as effective as the original.

_____

Signature of Patient, Parent, Guardian, or Personal Representative