PATIENT HEALTH HISTORY

Patient's Name: _____ (Last / First / Middle) **Date:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Birth date:** _____ **Social Security #:** _____

If patient is a minor, give Parent or Guardian's Name: _____

Whom may we thank for referring you to our office? _____

RESPONSIBLE PARTY INFORMATION

Name: _____ (Last / First / Middle) **Marital Status:** _____

Residence: _____ (Number & Street / City / State / zip)

Mailing Address: _____ (Number & Street / City / State / zip)

How long at this address? _____ **D.O.B:** _____ **Social Security #:** _____

Home Phone: _____ **Work Phone:** _____ **Relationship to Patient:** _____

Employer: _____ **Occupation:** _____ **# Years Employed:** _____

Spouse's Name: _____ (Last / First / Middle) **Social Security #:** _____

Employer: _____ **#Years Employed:** _____ **D.O.B.:** _____

INSURANCE INFORMATION

Insured's Name: _____ **Insured's S.S.#:** _____

Insurance Company: _____ **Group No.:** _____

Address to Mail Claims To: _____

Insurance Phone Number: _____ **Insured's Employer:** _____

Do You Have Dual Coverage? **Yes No** ***If Yes, Please fill in the following & see the front desk for stipulations regarding such.***

Insured's Name: _____ **Insured's S.S.#:** _____

Insurance Company: _____ **Group No.:** _____

Address to Mail Claims To: _____

Insurance Phone Number: _____ **Insured's Employer:** _____

EMERGENY INFORMATION

Name of nearest relative not living with you: _____

Complete Address: _____

Phone#: _____ **Relationship to Patient:** _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent or Guardian's of minor): _____

Updates (Date & Initial): _____

MEDICAL INFORMATION

Name of Physician:_____ **Physician Phone:**_____

Last visit with Physician:_____ **Current Health:** □ Excellent □ Good □ Fair □ Poor

Do you smoke or use Chewing Tobacco? □ Yes □ No **If yes, how much per day?**_____

Are you taking any medications? □ Yes □ No **If yes, please specify with names & purposes:**_____

Have you had any serious medical problems with in the past 5 years, including illnesses, operations, or hospitalizations?

Have you ever had, or been treated for any of the following diseases or medical problems?

☐ Y ☐ N Abnormal Bleeding
☐ Y ☐ N AIDS or HIV
☐ Y ☐ N Anemia
☐ Y ☐ N Arthritis/Rheumatoid
☐ Y ☐ N Asthma
☐ Y ☐ N Blood Transfusion
☐ Y ☐ N Cancer/Chemotherapy/Radiation
☐ Y ☐ N Cardiovascular disease:
If yes, please specify:
☐ Angina
☐ Arteriosclerosis
☐ Artificial Heart Valve
☐ Coronary Insufficiency
☐ Damaged Heart Valve
☐ Heart Attack
☐ Heart Murmur
☐ High Blood Pressure
☐ Inborn Heart Defect
☐ Mitral Valve Prolapse
☐ Pacemaker
☐ Rheumatic Heart Disease
☐ Y ☐ N Chest Pain Upon Exertion
☐ Y ☐ N Chronic Pain
☐ Y ☐ N Persistent Diarrhea
☐ Y ☐ N Sinus Trouble
☐ Y ☐ N Stroke
☐ Y ☐ N Thyroid Problems

☐ Y ☐ N Diabetes
☐ Type I (Insulin Dependent)
☐ Type II
☐ Y ☐ N Dry Mouth
☐ Y ☐ N Eating Disorder
If Yes, Specify:_____
☐ Y ☐ N Epilepsy
☐ Y ☐ N Fainting Spells or Seizures
☐ Y ☐ N G.E. Reflux
☐ Y ☐ N Glaucoma
☐ Y ☐ N Hemophilia
☐ Y ☐ N Hepatitis, Jaundice, Liver Disease
☐ Y ☐ N Kidney Problems
☐ Y ☐ N Low Blood Pressure
☐ Y ☐ N Mental Health Disorders, Specify:
_____
☐ Y ☐ N Persistent Swollen Glands in Neck
☐ Y ☐ N Respiratory Problems:
☐ Emphysema
☐ Bronchitis
☐ Y ☐ N Severe Headaches
☐ Y ☐ N Severe or Rapid Weight Loss
☐ Y ☐ N Sexually Transmitted Disease
☐ Y ☐ N Sores or Ulcers in Mouth
☐ Y ☐ N Systemic Lupus Erythematosus
☐ Y ☐ N Tuberculosis
Are you allergic to any other medications?_____

☐ Y ☐ N Do you have any disease, condition, or problem not listed that we should know about?

☐ Y ☐ N Do you need to be pre-medicated before dental treatment? Explain:_____
_____

Are you allergic to any of the following medications?
☐ Y ☐ N Local Anesthetics
☐ Y ☐ N Aspirin
☐ Y ☐ N Penicillin or Other Antibiotics?
☐ Y ☐ N Sulfa Drugs
☐ Y ☐ N Darvon
☐ Y ☐ N Barbiturates, Sedatives, or Sleeping Pills?
☐ Y ☐ N Latex
☐ Y ☐ N Lodine
☐ Y ☐ N Hay Fever/Seasonal
☐ Y ☐ N Codeine or Narcotics
☐ Y ☐ N Nitrous Oxide

Women Only: This can affect your treatment. **Are you pregnant?** ☐ Y ☐ N If yes, How far long?_____

Do you plan on becoming pregnant in the near future and when? _____

I certify that I have read & understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any 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.

Patient Signature:_____ **Date:**_____

CONSENT: The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any & all forms of treatment or medication & therapy that may be indicated in connection with (Name of Patient)_____, And further authorize & consent that Doctor choose & employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk.

Patient Signature:_____ **Date:**_____