Health Information

OUR STAFF TAKES YOUR ORAL HEALTH VERY SERIOUSLY. WE NEED SOME BRIEF INFORMATION ON YOUR MEDICAL HISTORY AS IT MAY AFFECT DENTAL TREATMENT.

ALL INFORMATION IS CONFIDENTIAL.

PERSONAL INFORMATION

Name: Last First Middle

Home Phone: Include area code ( )

Cell Phone: Include area code ( )

Mailing Address: City: State: Zip:

Date of Birth: Occupation: Sex: (circle) M F

If you are completing this form for another person, what is your relationship to that person?
Your Name: Relationship:

Email Address:

DENTAL HISTORY	Yes	No		Yes	No
Do your gums bleed when you brush or floss?	☐	☐	Do you have earaches or neck pains?	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	Do you have any clicking, popping or discomfort in the jaw?	☐	☐
Does food or floss catch between your teeth?	☐	☐	Do you clench or grind your teeth?	☐	☐
Have you ever had any gum treatments or deep cleaning?	☐	☐	Date of last dental exam:		
Have you had your wisdom teeth removed?	☐	☐			
Date of last dental x-rays:			Date of last dental cleaning:		
How do you feel about your smile?			Are you interested in tooth whitening or cosmetic procedures?		
Are you missing any teeth?			Would you like to replace any missing teeth?		
If wearing dentures or partials, age of dentures:			Are you interested in new dentures?		

List any medications your are taking including non-prescription drugs including herbals/vitamins:

1._____ 2. _____ 3._____ 4. _____
5._____ 6. _____ 7._____ 8. _____

ALLERGIES- Are you allergic to or have you had a reaction to:	Yes	No		Yes	No
Local anesthetics	☐	☐	Latex (rubber)	☐	☐
Penicillin or other antibiotics	☐	☐	Metals	☐	☐
Codeine or other narcotics	☐	☐	Food	☐	☐
Aspirin	☐	☐	Hay fever/seasonal	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐	Other	☐	☐

MEDICAL HISTORY

Are you taking or have taken Oral Bisphosphonates, e.g., FOSAMAX, ACTONEL, BONIVA, or IV Bisphosphonates, e.g., ZOMETA, AREDIA? (circle) Yes No
Taken for how long?_____

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

Have you ever had?	Yes	No		Yes	No
Joint replacement, e.g., knee, hip?	☐	☐	Radiation treatments?	☐	☐
Artificial (prosthetic) heart valve?	☐	☐	Chemotherapy?	☐	☐
Previous infective endocarditis?	☐	☐	Pacemaker?	☐	☐

Do YOU have a history of:	**Y**	**N**		**Y**	**N**		**Y**	**N**		**Y**	**N**
Heart Disease			Aspirin/Anticoagulants			Rheumatic fever			Use of tobacco products		
Heart attack, heart defects			Excessive bleeding			Asthma			Drug addiction		
Stroke			Dialysis			Psychiatric treatment			Alcoholism		
High blood pressure			HIV positive/ AIDS			Hepatitis (Type:)			Other disease or illness:		
Diabetes			Cancer (Type:)			Liver disease					
Tuberculosis (TB)			Epilepsy or seizures			Stomach problems, ulcers					
Women											
Are you or could you be pregnant or nursing?						Are you taking any birth control prescriptions?					

NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician regarding additional birth control methods.

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's signature:_____Date:_____

Account Information

PERSONAL / FAMILY INFORMATION	
Your Name: Last First Middle	Who may we thank for referring you?
Other family members seen by us:	

SPOUSE INFORMATION	
Their Name:	Phone No.
Employer:	Birthdate:

PERSON RESPONSIBLE FOR ACCOUNT	
Their Name:	Phone No.
Billing Address:	
Relationship:	Employer:

PRIMARY DENTAL INSURANCE	
Insurance Co. Name:	Insured's Employer:
Insured's Name:	Relationship to Patient:
Insured's Birthdate:	Insured's SSN:
SECONDARY DENTAL INSURANCE	
Insurance Co. Name:	Insured's Employer:
Insured's Name:	Relationship to Patient:
Insured's Birthdate:	Insured's SSN:

EMERGENCY INFORMATION- In the event of an emergency, who should we contact?	
Their Name:	Relationship:
Home Phone #:	Work Phone #:

OFFICE USE ONLY – HEALTH INFORMATION UPDATES:

Date_____ Comments _____ Signature_____

Date_____ Comments _____ Signature_____

Date_____ Comments _____ Signature_____

Date_____ Comments _____ Signature_____

Date_____ Comments _____ Signature_____

Date_____ Comments _____ Signature_____

Date_____ Comments _____ Signature_____

Date_____ Comments _____ Signature_____