HEALTH HISTORY

YES NO

_____ _____ Are you in good health?
_____ _____ Has there been any change in your general health within the past year? If yes, explain_____
_____
My last physical exam was on _____
_____ _____ Are you under the care of a physician? If yes, what is the condition being treated?_____
_____
_____ _____ Have you had any serious illness or operation? If yes, what was the illness or operation?_____
_____
_____ _____ Are you taking any drug or medicine? If yes, please list_____
_____
_____ _____ Have you had excessive bleeding requiring special treatment?
_____ _____ Have you had any adverse drug reaction? Explain_____
_____ _____ Do you smoke?

ARE YOU ALLERGIC TO:
_____ _____ Local anesthetics (for example - novocaine or lidocaine)?
_____ _____ Penicillin or other antibiotic?
_____ _____ Sulfa drugs?
_____ _____ Barbiturates, sedatives, sleeping pills?
_____ _____ Codeine?
_____ _____ Aspirin?
_____ _____ Other drugs? If yes, please list_____
_____ _____ Do you have any other allergies?

HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS:
_____ _____ Rheumatic Fever?
_____ _____ Heart disease or heart murmur?
_____ _____ Any heart prosthesis (pacemaker, heart valves)?
_____ _____ Stroke?
_____ _____ Diabetes?
_____ _____ High or low blood pressure?
_____ _____ Liver or kidney disorders (hepatitis, nephritis)?
_____ _____ Respiratory disorders (tuberculosis, asthma, hay fever)?
_____ _____ Sinus problems?
_____ _____ Arthritis?
_____ _____ Artificial joints?
_____ _____ Anemia?
_____ _____ Hives or skin rash?
_____ _____ Nervous disorders or psychiatric care?
_____ _____ Epilepsy?
_____ _____ Fainting spells or seizures?
_____ _____ Stomach ulcers?
_____ _____ Cancer?
_____ _____ Alcoholism or drug addiction?
_____ _____ Sexually transmitted diseases (Syphilis, Gonorrhea, Herpes)?
_____ _____ AIDS or other immunosuppressive disorders?
_____ _____ Have you ever had a blood transfusion? If so, when_____
_____ _____ Do you have any disease, condition, or problem not listed above that we should know about? If yes, explain_____
_____

Please list the names of individuals you permit us to discuss your dental treatment:_____
_____

WOMEN
_____ _____ Are you pregnant? If yes, due date is_____
_____ _____ Are you taking birth control pills or other hormonal therapy?
_____ _____ Osteopenia or Osteoporosis?

In the future please inform us of any change in your medical history, address, or phone number.
I certify that I have read and understand the above. I will not hold my dentist, or any member of the staff, responsible for any errors or omissions that I may have made in the completion of this form.

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Patient's Signature_____Date_____

DENTAL HISTORY

What is your chief complaint?_____

_____

YES NO

_____ _____ Are you having any discomfort at this time?
How long since your last dental visit?_____
What was done then?_____
How often did you visit a dentist before then?_____
_____ _____ Have you lost any teeth? Why?_____
Have they been replaced by: Fixed Bridge _____, Denture_____?
_____ _____ Any complications with extractions?_____
_____ _____ Are your teeth sensitive to: Heat____, Cold____, Sweets____?
_____ _____ Does food wedge between your teeth? Where?_____
_____ _____ Do you have bleeding gums? When?_____ Where?_____
_____ _____ Do you grind or clench your teeth? When?_____
_____ _____ Do you get frequent headaches?
_____ _____ Do you have upper or lower back pain?
_____ _____ Do you have neck pain?
_____ _____ Have you had your teeth straightened? When?_____
_____ _____ Have you ever had gum treatment? When?_____
_____ _____ Any pain in or around your ears?_____
_____ _____ Are you aware of any swelling or lump in your mouth? Where?_____
How often do you brush your teeth?_____ When?_____
_____ _____ Do you use dental floss? How often?_____
How long do you use a toothbrush before replacing it?_____
_____ _____ Do you have any fear of dental treatment? If yes, explain_____
_____ _____ Have you had any serious trouble associated with any previous treatment? If yes, explain_____
_____
_____ _____ Is there anything you want to change about your smile? If yes, explain _____
_____

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Today's Date _____

We would like to get to know you better. It is important that we know about your dental and medical history since many things have a direct bearing on your dental health. Information you give to us is strictly confidential and will not be released to anyone without your permission.

Please complete all sections.

Name _____ Age _____ Date of Birth _____
Nickname _____ Social Security Number _____
Mailing Address _____ City _____ Phone _____
Street Address _____ City _____
Occupation _____ E-mail Address _____ Cell Phone _____
Business Name & Address _____ Business Phone _____
Single _____ Married _____ Divorced _____ Separated _____ Widowed _____
Name of Spouse _____ Occupation _____
Business Name & Address _____ Business Phone _____
Name of Previous Dentist _____ Emergency Contact _____ Phone _____
Address _____ City _____ Phone _____
Name of Physician _____ City _____ Phone _____
Patient Referred By _____ Person Who Will Pay for this Account _____
Name of Dental Insurance Company(s) _____ Policy # _____
Address _____ Ins. Co. Phone Number _____
Insured's SS # _____ Insured's Birth Date _____ Insured's Name _____

In the event that my account becomes delinquent for more than 60 days, I also agree to pay a finance charge of 1.5% per month on any balance due, as well as all collection costs, court costs, attorney fees, and interest fees accrued with the collection of this account.

Patient Signature _____