Health History Form

Today's Date: _____ E-Mail: _____

Patient Name: _____ Preferred Name: _____
First MI Last

Sex: M F Date of Birth: _____ /_____ /_____ (MM/DD/YYYY) Social Security No.: _____-_____-_____

Home Phone: _____ Cell Phone: _____ Business Phone: _____

Address: _____ City/State: _____ Zip: _____

Occupation: _____ Family Status: ___ Married ___ Single ___ Child ___ Other

Emergency Contact: _____
Name Relationship His/Her Phone No.

Are you completing form for another person? **Yes** **No** If yes, what is your relationship? _____

COMMUNICATION

Would you like to receive dental appointment reminders by text and/or e-mail? **Yes** ____ **No** ____
May we leave personal/medical/billing information on your voicemail/answering machine? **Yes** ____ **No** ____
May we call you on your home/cell phone regarding personal/medical/billing information? **Yes** ____ **No** ____

Do you have any of the following diseases or problems: (DK = Don't Know Answer to Question)

Active Tuberculosis? _____(Y/N/DK)
Persistent cough greater than a 3 week duration? _____(Y/N/DK)
Cough that produces blood? _____(Y/N/DK)
Been exposed to anyone with Tuberculosis? _____(Y/N/DK)

If you have answered yes to any of the above questions, please stop and return this form to the Front Desk.

Dental Information (Y / N / DK)

Do your gums bleed when you brush or floss?		Do you have earaches or neck pains?	
Are your teeth sensitive to cold, hot, sweets, pressure?		Do you have clicking, popping, or jaw discomfort?	
Is your mouth dry?		Do you brux or grind your teeth?	
Have you had any periodontal (gum) treatments?		Do you have sores or ulcers in your mouth?	
Have you ever had orthodontic treatment?		Do you wear dentures or partials?	
Have you had any problems associated with previous dental treatment?		Do you participate in active recreational activities?	
Is your home water supply fluoridated?		Have you ever had serious injury to your head or mouth?	
Do you drink bottled or filtered water? If yes, how often? Daily / Weekly / Occasionally		Date of your last dental exam: _____ What was done at that time?	
Are you currently experiencing dental pain or discomfort?		Date of last dental x-rays:	
What is the reason for your dental visit today?		How do you feel about your smile?	

Medical Information

Are you in good health? Have there been any changes in your general health within the past year? If yes, what condition is being treated?		Have you had a serious illness, operation or been hospitalized in the past 5 years? If yes, what was the illness/problem?	
Are you now under the care of a physician? Physician Name: Phone: ( ) Address:		Please list all medications, including vitamins, natural/herbal and/or diet supplements: *If you have a separate list, we can make a copy for your chart.* _____ _____ _____ _____	
Date of last physical exam:			
Are you taking, or recently taken any prescription or over-the-counter medicine(s)?			
Do you wear contacts?		Do you use controlled substances (drugs)?	
Are you taking, or have taken, any diet drugs such as Pondimin (fenflluramine), Redux (dexphenfluramine), or phen-fen (fenflluramine-phentermine combination)?		Do you use tobacco (smoking, snuff, chew, bidis)? If so, are you interested in stopping?	
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosomax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?		Do you drink alcoholic beverages? If yes, how much have you had in the last 24 hours? If yes, how much do you typically drink in a week?	
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Date to begin treatment: _____		**Woman Only** Are you: Pregnant? Yes or No Number of weeks: _____ Taking birth control pills or hormonal replacement? Yes or No Nursing? Yes or No	
Joint Replacement: Have you had an orthopedic total joint (hip, knee, elbow, or finger) replacement? Date: _____ Did you have complications?			

Allergies: Are you allergic to or have had a reaction to any of the below: (Please circle **Y** / **N** / **DK**)
If yes, please specify type of reaction.

Local anesthetics: …….…… Y / N / DK Aspirin: ……..……Y / N / DK Penicillin or other antibiotics: ……..…. Y / N / DK Barbiturates, sedatives, or sleeping pills: …..… Y / N / DK Sulfa drugs: ……..… Y / N / DK Codeine or other narcotics: ……..…… Y / N / DK Other:		Metals: ……...…… Y / N / DK Latex: ……..… Y / N / DK Iodine: …… Y / N / DK Hay fever/seasonal: ……..…… Y / N / DK Animals: ……..…… Y / N / DK Food: ……..…… Y / N / DK	

Please rate your dental anxiety:

1	5	10
Low	**Moderate**	**High**

We make every effort to be extremely gentle, caring and patient to put you at ease and address your apprehensions. If you have concerns about dental fears and anxieties, feel free to speak with Dr. Jones personally so we can work through it together.

Please mark Y / N / DK to your response to indicate if you have or had any of the following diseases/problems.

Angina: Y / N / DK	Rheumatic heart disease: Y / N / DK	Epilepsy: Y / N / DK
Anemia: Y / N / DK	Low or High blood pressure: Y / N / DK	Autoimmune disease: Y / N / DK
Pacemaker: Y / N / DK	Stroke: Y / N / DK	Sinus trouble: Y / N / DK
Arteriosclerosis: Y / N / DK	Coronary artery disease: Y / N / DK	Kidney problems: Y / N / DK
Blood transfusion: Y / N / DK	Congenital heart defects: Y / N / DK	Diabetes (Type I or II): Y / N / DK
Chest pain upon exertion: Y / N / DK	Fainting spells or seizures: Y / N / DK	Chronic pain: Y / N / DK
Mitral valve prolapse: Y / N / DK	Osteoporosis: Y / N / DK	Sexually Trans. Disease: Y / N / DK
Abnormal Bleeding: Y / N / DK	Asthma: Y / N / DK	AIDS / HIV: Y / N / DK
Artificial Heart Valve: Y / N / DK	Thyroid problems: Y / N / DK	Hepatitis: Y / N / DK
Heart attack: Y / N / DK	Arthritis: Y / N / DK	HPV: Y / N / DK
Cardiovascular disease: Y / N / DK	Bronchitis: Y / N / DK	Ulcers: Y / N / DK
Congestive heart failure: Y / N / DK	Glaucoma: Y / N / DK	Excessive Urination: Y / N / DK
Heart murmur: Y / N / DK	Rheumatoid arthritis: Y / N / DK	
Hemophilia: Y / N / DK	Emphysema: Y / N / DK	
Mental Disorders: Y / N / DK Specify: _____	Recurrent infections: Y / N / DK Specify: _____	Neurological disorders: Y / N / DK Specify: _____
Persistent swollen glands in neck: Y / N / DK	Systemic lupus erythematosus: Y / N / DK	Severe headaches or migraines: Y / N / DK

Has a physician or previous dentist recommended that you take antibiotics prior to dental treatment? Y / N / DK

Name of physician or dentist making recommendation: _____ Phone: _____

Do you have any disease, condition, or problem not listed above that you think the dentist should know about? Yes/No/DK
Please explain: _____

Note: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and her staff will rely on this information for treating me. 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 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/Legal Guardian Signature Date

INSURANCE:

Please give your insurance card to someone at the front desk. If you are not the subscriber of the plan, please provide us the following information:

Name of Subscriber: _____ Relationship to Subscriber: _____

Date-of-Birth of Subscriber: _____ Social Security No.: _____
**If the card has an alternative ID No., we will not need this.

Dental Benefits Carrier: _____