PATIENT HEALTH HISTORY

An essential part of our approach is a thorough health history. Please fill out this health questionnaire completely even if some of the questions may not seem relevant to your health. Your answers are for our records only and will be kept confidential in accordance with applicable laws.

DATE:		MEDICAL FORM UPDATED:
FULL NAME (Last, First, Middle):		
STREET ADDRESS:		
CITY, STATE, ZIPCODE:		
HOME PHONE:		
BUSINESS PHONE:		
CELL PHONE:		
EMAIL:		
REFERRED BY:		

PLACE OF EMPLOYMENT:	
STREET ADDRESS:	
CITY, STATE, ZIPCODE:	

DATE OF BIRTH:	
SEX:	☐ MALE ☐ FEMALE
DRIVER'S LICENSE NUMBER:	
MARITAL STATUS:	☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED
SOCIAL SECURITY NUMBER:	
SPOUSE'S OR PARENT'S NAME:	
PERSON RESPONSIBLE FOR ACCOUNT:	
DENTAL INSURANCE CO.:	
GROUP / PLAN #:	
GENERAL HEALTH:	☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR
EMERGENCY CONTACT:	
PHONE:	
NAME OF PHYSICIAN:	
PHONE:	
PHARMACY:	

PLEASE LIST ALL MEDICATIONS:

Are you subject to prolonged bleeding or are you taking any blood thinners?
(I.e.- Coumadin, Aspirin, Advil)

Are you taking any of the following bisphoshonate medicines for Osteoporosis?
(Actonel, Fosamax, Boniva, Didronel, Skelid)

Are You Allergic to:
☐Penicillin ☐Codeine ☐Local Anesthetic ☐Sulfa ☐Latex ☐Other:_____

Do You Have Now or Have You Ever Had:

- ☐Abnormal Blood Pressure
- ☐Acid Reflux Disease
- ☐Alzheimer's Disease
- ☐Anemia
- ☐Arthritis
- ☐Asthma
- ☐Blood Diseases
- ☐Cancer
  - ☐Chemo Treatments
  - ☐Radiation Treatments
  - ☐Tumors and/or Biopsies
- ☐Diabetes
- ☐Drug Addiction
- ☐Emphysema/COPD
- ☐Glaucoma
- ☐Heart Disease
  - ☐Angina
  - ☐Heart Attack
  - ☐Heart Murmur
  - ☐Mitral Valve Prolapse
  - ☐Pacemaker
  - ☐Prosthetic Heart Valve
- ☐Hepatitis:
  - ☐A
  - ☐B
  - ☐C
- ☐Hip/Knee or Other Joint Replacement
- ☐HIV or AIDS
- ☐Jaundice
- ☐Kidney Trouble
  - ☐Dialysis Treatments
- ☐Liver Disease
- ☐Parkinson's Disease
- ☐Psychiatric Care
- ☐Osteoporosis
- ☐Respiratory Problems
- ☐Rheumatic Fever
- ☐Seizure or Epilepsy
- ☐Sinus Problems
- ☐Stroke
- ☐Thyroid Problems
- ☐Transplants
- ☐Tuberculosis
- ☐Ulcers
- ☐Others: _____

Do you smoke?

How many packs per day?

Soda consumption per day:

Candy consumption per day:

FEMALE PATIENTS		
Are You Currently Pregnant/Trying to Get Pregnant?	☐Yes	☐No
Are you nursing?	☐Yes	☐No
Expected delivery date:		
Are you taking birth control pills?	☐Yes	☐No

Note: Antibiotics (such as penicillin) may alter effectiveness of birth control pills. If you are taking antibiotics and birth control pills we highly recommend that you consult your physician/gynecologist for assistance regarding additional methods of birth control.

1. The undersigned hereby authorizes doctor or designated staff 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.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using aesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor chooses and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for my dependents or myself is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates I understand that a 1.5% finance charge (18% APR) may be added to my account, in addition to any collection charges.
4. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

SIGNATURE: _____ Date: _____/_____/_____

Personal/Medical:	History Med Alert: