Health History Form

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Family and Cosmetic Dentistry

E-mail : Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. This information is vital to allow us to provide appropriate care for you. The office does not use any information to discriminate.

Patient:

First Name Middle Last Name

(Preferred Name)

Birthdate____ ____ ____ Age_____ Sex M_____ F_____

How did you hear about us?
Insurance company_____ Office Sign_____ Family/Friend_____
Facebook/Web Page_____ Other _____

Home# _____ _____
Cell# _____ _____
Work#_____ _____
Preferred method of contact:
HOME____ CELL____ WORK____ EMAIL____

Address: _____

Subscribers Insurance Information:

Name of insurance _____

Subscriber Name _____ Subscribers Date Of Birth _____
Subscribers ID#/SS# _____ Group # _____
Relationship to Subscriber: Spouse/Partner_____ Child_____ Other _____

Authorization for Use or Disclosure of Patient Information:

The following person(s) may receive this patient information:
Name_____ Relationship_____
Name_____ Relationship_____
I hereby authorize the use and disclosure of all of my patient information. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPPA Privacy regulations. I also understand that if at any time I wish to change or amend this authorization, I will need to do so in writing.

In Case of Emergency:

Name:_____ Phone #_____
Relationship_____

Dental Information: *For the following questions, please mark (x) your response.*

	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 hot, cold, sweets or pressure?	☐	☐	Do you have any clicking, popping or discomfort in the jaw?	☐	☐
Does food or floss catch between your teeth?	☐	☐	Do you grind your teeth?	☐	☐
Is your mouth dry?	☐	☐	Do you have any sores or ulcers in your mouth?	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	Do you wear dentures or partials?	☐	☐
Have you had any orthodontic (braces) treatment?	☐	☐	Have you ever had any serious injury to your head or mouth?	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	Do you snore?	☐	☐
			Do you have any trouble sleeping?	☐	☐

What is the reason for your dental visit today? _____
Date of your last dental examination? ____ ____ _____
Do you like your smile? YES☐ NO☐
What Changes would you like to make?_____
_____

MEDICAL INFORMATION:

Please mark (x) your response to indicate if you have or have not had any of the following.

	YES	NO
Are you now under the care of a physician?	☐	☐

Physician Name:_____

Phone # (_____) _____

Date of Last Exam: _____

	YES	NO
Have you had any serious illness, operations or been or been hospitalized?	☐	☐

If yes, what was the illness or problem?_____

_____

_____

_____

_____

_____

	YES	NO
Joint Replacement: Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐
Date of Replacement:_____		
Artificial Heart Valves?	☐	☐
Congenital Heart Disease (CHD)?	☐	☐
Has a physician and/or previous dentist recommended that you take Antibiotics prior to your dental appointments?	☐	☐

	YES	NO
Do you use controlled substances (drugs)?	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐
If so, how interested are you in stopping?		
(circle one) VERY / SOMEWHAT / NOT INTERESTED		
Do you drink alcoholic beverages?	☐	☐

If yes, how much do you typically drink in a week? _____

WOMEN ONLY: Are you:

Pregnant? _____ **Number of weeks** _____

Taking birth control or hormonal replacement?_____

Nursing?_____

MEDICATIONS Please list all prescription, vitamins, natural, herbal and/or diet supplements

_____

_____

_____

_____

ALLERGIES – Are you allergic to or have you had a reaction to:

To all **yes** responses, specify type of reaction.

	YES	NO
Local anesthetics	☐	☐
Aspirin	☐	☐
Penicillin or other antibiotics	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐
Sulfa Drugs	☐	☐
Codeine and other narcotics	☐	☐
Metals	☐	☐
Latex (rubber)	☐	☐
Iodine	☐	☐
Hay fever/seasonal	☐	☐
Animals	☐	☐
Food	☐	☐
Other	☐	☐

PLEASE MARK (X) YOUR RESPONSE TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS

- ☐ Arthritis
- ☐ Back Problems
- ☐ Bleeding Abnormalities
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chronic Diarrhea
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Headaches
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ High Blood Pressure
- ☐ HIV/AIDS or STD
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stomach / Intestinal Disease
- ☐ Stroke
- ☐ Swollen Neck Glands
- ☐ Thyroid Disease

Do you have any disease, condition or problem not listed above that you think I should know about? _____

_____

_____

_____

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 his/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 other 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.**

_____ DATE: _____