HEALTH HISTORY – ADULT

OOSTBURG FAMILY DENTISTRY
DANIEL R. BRUHN, D.D.S.
JORDAN D. MOLTER, D.D.S.

Today's Date:

PATIENT INFORMATION

Last Name:	First:	Middle:
Date of Birth:	Age:	Sex: ❒ M ❒ F

HEALTH HISTORY

Are you generally in good health? **Yes** **No**

Are you taking any medications? **Yes** **No** *Please list:*

Are you under a physician's care? **Yes** **No** *Reason:*

Date and purpose of last physical exam:

Name of physician: City:

Do you need pre-medication for dental work? **Yes** **No** *Reason:*

(*Women*) Are you pregnant or suspect you might be? **Yes** **No**

Have you ever taken, now or in the past, bisphosphonate medications for osteoporosis or bone cancer? **Yes** **No** If so, which one(s) and when?

Please check all that you have had:

❒ chronic fainting/dizziness
❒ excessive bleeding
❒ blood transfusion
❒ high blood pressure
❒ low blood pressure
❒ anemia
❒ diabetes
❒ asthma

❒ heart trouble
❒ heart murmur
❒ heart valve deficiency
❒ pacemaker
❒ rheumatic fever
❒ artificial joint
❒ kidney infection
❒ hepatitis

❒ radiation treatment
❒ tuberculosis
❒ malignant hyperthermia
❒ HIV infection or AIDS
❒ reaction to dental anesthetic
❒ latex allergy
❒ allergy to penicillin
❒ other drug allergy/reaction_____
_____

What else should we know about your health? _____
_____

AUTHORIZATION

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balance. I authorize Oostburg Family Dentistry and my insurance company to release any information required to process my claims.

_____ _____
Patient or Guardian Signature Date

revised July 2023