Patient Information and Health History Form

Last Name ______ First ______ Middle ______

Address ______ City ______ Zip ______

Home phone # ______ Cell phone # ______ Birthdate ______ SSN/ID# ______

Sex (Please circle) F M ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Minor

Spouse's name ______ Birthdate ______ Employer ______

Whom may we thank for referring you? ______________________________ Reason for today's visit? ________________________

Referring Dentist:________________________________ Date of last visit: ___________ Date of last dental x-rays: ___________

Who is your Physician: ____ What Pharmacy do you use: _______________________________

DENTAL INSURANCE: Do you have dental insurance? (Please circle) Yes / No

Name of Employer: ________________________________ Name of Insurance Company: ___________________________________

Claims Address: __________________________________ Phone # _________________ Group # ____________________________

Name of Policy Holder: _________________________ Social Security/ID #: __________________ Birth-date: __________________

Do you have a second dental insurance? (Please circle) Yes / No

Name of Employer: ________________________________ Name of Insurance Company: ___________________________________

Claims Address: __________________________________ Phone # _________________ Group # ____________________________

Name of Policy Holder: _________________________ Social Security/ID #: __________________ Birth-date: __________________

I, the undersigned certify that I (or my dependent) understand I am responsible for all charges whether or not paid by my insurance.

I authorize the use of this signature on all insurance submissions and release all payments to be made to the treating doctor.

* ____

RESPONSIBLE PARTY SIGNATURE

Privacy Policy (HIPAA)

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. Please note that you will be asked some questions about your response to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Also by signing I agree to receive electronic communication, if desired. My email address is: ____

* ____

PATIENTS/PARENTS SIGNATURE DATE DOCTORS SIGNATURE

Patient Name: ____________________________

MEDICATIONS: List medications you are taking (a copy of a list is acceptable)

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____

ALLERGIES: (please circle all that apply)

Codeine Penicillin Iodine Barbiturates (sleeping pills) Aspirin Sulfa Local Anesthetics Latex

Other allergies (please list any other allergies) ____

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MEDICAL HISTORY: (please circle Y/N for known conditions)

Y / N Aids	Y / N Epilepsy	Y / N Psychiatric Care
Y / N Anemia	Y / N Emphysema	Y / N Radiation Treatment
Y / N Arthritis/Rheumatism	Y / N Fainting or Dizziness	Y / N Respiratory Disease
Y / N Artificial Heart Valves	Y / N Glaucoma	Y / N Rheumatic Fever
Y / N Artificial Joints	Y / N Headaches	Y / N Scarlet Fever
Y / N Asthma	Y / N Heart Murmur	Y / N Shortness of Breath
Y / N Back Problems	Y / N Heart Problems	Y / N Sinus Trouble
Y / N Bleeding Abnormally	Y / N Hepatitis: A B C	Y / N Skin Rash
Y / N Cancer	Y / N High Blood Pressure	Y / N Stroke
Y / N Chemical Dependency	Y / N Jaundice	Y / N Swelling of feet or ankles
Y / N Chemotherapy	Y / N Kidney Disease	Y / N Swollen Neck Glands
Y / N Circulatory Problems	Y / N Liver Disease	Y / N Thyroid Problems
Y / N Congenital Heart Lesions	Y / N Low Blood Pressure	Y / N Tonsillitis
Y / N Cortisone Treatments	Y/ N Mitral Valve Prolapse	Y / N Tuberculosis
Y / N Cold Sores	Y / N Nervous Problems	Y / N Tumor / Growth on: Head / Neck
Y / N Diabetes	Y / N Pacemaker	Y / N Ulcer
Y / N Venereal Disease	Y / N Weight Loss (unexplained)	Other: __________________________

Do you wear contact lenses: Y / N

Are you pregnant? Y / N Due Date: ______________ Are you nursing? Y / N

Have you ever taken: Fen-Phen? Y / N Redux? Y /N FOSAMAX / BONIVA (Bisphosphonate) Y / N When? ______________

DENTAL HISTORY: (please circle all that apply)

Bad breath	Burning sensation on tongue	Loose teeth or broken fillings
Bleeding gums	Blisters/sores: on lips / in mouth	Chew on one side of mouth
Mouth breathing	Cigarette, pipe or cigar smoking	Mouth pain when brushing
Dry mouth	Clicking or popping jaw	Orthodontic / Periodontal treatment
Fingernail biting	Pain around ear	Gums swollen / tender
Grinding teeth	Food collects between teeth	Sensitivity to: cold / sweets / heat
Jaw pain or tiredness	Lip or cheek biting	Other: __________________________

How often do you floss: _____________________ How often do you brush: _____________________

UPDATES (to be filled in at future appointments)

Changes ____ Signature _____________________ Date ___________ BP _______ Initials ________

Changes ____ Signature _____________________ Date ___________ BP _______ Initials ________

Changes ____ Signature _____________________ Date ___________ BP _______ Initials ________

Changes ____ Signature _____________________ Date ___________ BP _______ Initials ________