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: _____

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PATIENTS/PARENTS SIGNATURE DATE DOCTORS SIGNATURE

Patient Name: _____

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

_____

_____

ALLERGIES: (please circle all that apply)

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

Other allergies (please list any other allergies) _____

_____

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

Y / N Aids
Y / N Anemia
Y / N Arthritis/Rheumatism
Y / N Artificial Heart Valves
Y / N Artificial Joints
Y / N Asthma
Y / N Back Problems
Y / N Bleeding Abnormally
Y / N Cancer
Y / N Chemical Dependency
Y / N Chemotherapy
Y / N Circulatory Problems
Y / N Congenital Heart Lesions
Y / N Cortisone Treatments
Y / N Cold Sores
Y / N Diabetes
Y / N Venereal Disease

Y / N Epilepsy
Y / N Emphysema
Y / N Fainting or Dizziness
Y / N Glaucoma
Y / N Headaches
Y / N Heart Murmur
Y / N Heart Problems
Y / N Hepatitis: A B C
Y / N High Blood Pressure
Y / N Jaundice
Y / N Kidney Disease
Y / N Liver Disease
Y / N Low Blood Pressure
Y/ N Mitral Valve Prolapse
Y / N Nervous Problems
Y / N Pacemaker
Y / N Weight Loss (unexplained)

Y / N Psychiatric Care
Y / N Radiation Treatment
Y / N Respiratory Disease
Y / N Rheumatic Fever
Y / N Scarlet Fever
Y / N Shortness of Breath
Y / N Sinus Trouble
Y / N Skin Rash
Y / N Stroke
Y / N Swelling of feet or ankles
Y / N Swollen Neck Glands
Y / N Thyroid Problems
Y / N Tonsillitis
Y / N Tuberculosis
Y / N Tumor / Growth on: Head / Neck
Y / N Ulcer
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
Bleeding gums
Mouth breathing
Dry mouth
Fingernail biting
Grinding teeth
Jaw pain or tiredness

Burning sensation on tongue
Blisters/sores: on lips / in mouth
Cigarette, pipe or cigar smoking
Clicking or popping jaw
Pain around ear
Food collects between teeth
Lip or cheek biting

Loose teeth or broken fillings
Chew on one side of mouth
Mouth pain when brushing
Orthodontic / Periodontal treatment
Gums swollen / tender
Sensitivity to: cold / sweets / heat
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 _____