Health History Form

PATIENT INFORMATION:

____

Last Name *First* *Middle* *Address* *City* *Zip*

____

Home# *Cell#* *Birthdate* *SSN/ID#*

Sex F M O Married O Single O Divorced O Separated O Widowed O Minor

Patient's Email Address ____

Spouse's name_____________________________________ **Birthdate** ____________________

Referring Dentist _________________________________**Reason for today's visit?**__________________

Physician:_________________________ **Pharmacy:**________________ **If Kaiser, ID #**____________

DENTAL INSURANCE: Do you have dental insurance? 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? 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:

***PATIENT SIGNATURE**____*

Privacy Policy

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.

PATIENT SIGNATURE _______________________ ***DATE***___________________________

Doctor's Signature_____________________________________

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

____

____

ALLERGIES: (please circle) ____

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

Other____

____

Please circle Y/N for known conditions:

Y/N AIDS
Y/N Anemia, Blood Disease
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 problem
Y/N Tonsillitis
Y/N Tuberculosis
Y/N Tumor/growth head or neck
Y/N Ulcer

Do you wear contact lenses?________Women: Are you pregnant?______ Due Date?________Are you nursing?____________

Patient Signature X____ **Date:** ____________________

Have you ever taken Fen-Phen? Y N Redux? Y N

Do you have a history of: FOSAMAX/BONIVA (Biophosphonate) Y N When? ________

***DENTAL HISTORY**: Please circle all that applies*

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, brushing
Orthodontic / Periodontal treatment
Gums swollen/tender
Sensitivity to: cold / sweets / heat

How often do you floss? __________________ How often do you brush? ___________________________

CANCELLATION POLICY

If you need to cancel your appointment, we respectfully request at least a 24-hour notice (*business day notice*: weekends and holidays do not count). Our policy: Any cancellation or reschedule made less than 24 hours before your visit will result in a **cancellation fee**. The amount of the fee is $25 per 30 minutes of time reserved for services. Please be advised cleanings are scheduled for 1 hr. (can be more) and most surgeries are scheduled for 1.5+ hrs.

Patient Signature X____ Date: _________________________