

Patient Health History

Please enter the following information into the form, and press the "Submit" button at the bottom of the page. This information is transmitted safely and securely protected for your confidentiality.

(*) indicates a required field

Patient Information

E-MAIL: *

PATIENT NAME: *

ADDRESS: *

CITY: *

STATE: *

ZIP: *

HOW LONG AT THIS ADDRESS:

HOME PHONE: *

CELL PHONE:

BIRTHDATE: *

SOCIAL SECURITY NUMBER:

IF PATIENT IS A MINOR, GIVE PARENT'S OR GUARDIAN'S NAME:

EMPLOYER:

WORK PHONE:

OCCUPATION:

TIME HERE:

SPOUSE NAME:

SPOUSE BIRTHDATE:

SPOUSE SOCIAL SECURITY NUMBER:

SPOUSE EMPLOYER:

SPOUSE OCCUPATION:

TIME HERE:

HOW DID YOU LEARN ABOUT OUR OFFICE:

IF YOU WERE REFERRED BY SOMEONE, WHOM MAY WE THANK?

Responsible Party / Billing Information

RESPONSIBLE PARTY NAME:

ADDRESS:

CITY:

STATE:

ZIP:

HOW LONG AT THIS ADDRESS:

HOME PHONE:

WORK PHONE:

SOCIAL SECURITY NUMBER:

BIRTHDATE:

RELATIONSHIP TO PATIENT:

EMPLOYER:

OCCUPATION:

TIME HERE:

SPOUSE NAME:

SPOUSE BIRTHDATE:

SPOUSE SOCIAL SECURITY NUMBER:

SPOUSE EMPLOYER:

SPOUSE OCCUPATION:

TIME HERE:

Insurance Information

INSURED'S NAME:

INSURED'S BIRTHDATE:

SSN / ID#:

INSURANCE COMPANY:

GROUP NUMBER:

INSURANCE PHONE:

ADDRESS:

CITY:

STATE:

ZIP:

DO YOU HAVE DUAL COVERAGE?

Yes No

INSURED'S NAME:

INSURED'S BIRTHDATE:

SSN / ID#:

INSURANCE COMPANY:

GROUP NUMBER:

INSURANCE PHONE:

ADDRESS:

CITY:

STATE:

ZIP:

Medical History

WHO IS YOUR PRIMARY CARE PHYSICIAN?

PHYSICIAN'S PHONE:

HOW WOULD YOU DESCRIBE YOUR OVERALL HEALTH?

WHEN WAS YOUR LAST PHYSICAL ?

HAVE YOU BEEN HOSPITALIZED UNDER A PHYSICIAN'S CARE IN THE LAST TWO YEARS?

Yes No

IF SO, WHY?

PLEASE LIST ALL MEDICATIONS/DRUGS YOU ARE TAKING:

HAVE YOU EVER HAD AN ADVERSE REACTION OR ALLERGIES TO ANY MEDICATION OR SUBSTANCE? (PLEASE CHECK IF ALLERGIC.)

Aspirin	Codeine
Valium	Iodine
Sulfa Drugs	Tetracycline
Penicillin	Erythromycin
Novocaine	Xylocaine
Nitrous Oxide	Latex

OTHERS:

HAVE YOU EVER HAD ANY OF THE FOLLOWING? (PLEASE CHECK ALL THAT APPLY)

Arthritis or Gout	Artificial Joint
Asthma	Allergies

Bleeding Problem or Anemia	Blood disease
Blood Transfusion	Bruise Easily
Cancer	Cold Sores
Congenital Heart Problems	Currently Pregnant
Diabetes	Dizziness or Fainting
Drug/Alcohol Addiction	Eating Disorder
Emphysema	Epilepsy or Seizures
Fever Blisters	Frequent Thirst
Frequent Urination	Glaucoma
Heart Attack or Stroke	Heart Murmur
Heart Trouble	Heart Valve or Pacemaker
Hepatitis (A)	Hepatitis (B)
Hepatitis (C)	Herpes
Low Blood Pressure	High Blood Pressure
HIV-AIDS-ARC	Hypoglycemia
Jaw Joint Pain	Kidney or Liver Disease
Lung Disease	Psychiatric Care
Radiation/Chemotherapy	Rheumatic Fever
Sinus Problems	Thyroid Problems
Tuberculosis	Tumor or Growth
Ulcers or G.I. Problems	Use Tobacco
X-ray/Chemotherapy	

**DO YOU HAVE ANY CONDITION OR PROBLEM NOT LISTED WHICH WE SHOULD KNOW ABOUT?
PLEASE EXPLAIN:**

HAVE YOU EVER BEEN GIVEN ANTIBIOTICS BEFORE DENTAL TREATMENT?

Yes No

HAVE YOU RECENTLY CONSUMED ALCOHOL?

Yes No

HAVE YOU RECENTLY USED RECREATIONAL DRUGS?

Yes No

Recreational use combined with local anesthesia may cause a life-threatening emergency.

Dental History

WHAT ARE YOUR PRESENT DENTAL CONCERNS?

WHEN WAS YOUR LAST DENTAL VISIT?

WHEN WERE YOUR LAST DENTAL X-RAYS?

WHEN WAS YOUR LAST CLEANING?

HAVE YOU AVOIDED REGULAR DENTAL CARE?

Yes No

WHY?

DO YOU FEEL YOU HAVE ACTIVE DECAY?

Yes No

DO YOU EXPERIENCE FREQUENT BAD BREATH?

Yes No

DO YOU FEEL YOU HAVE GUM DISEASE?

Yes No

HAVE YOU EVER HAD GUM TREATMENTS?

Yes No

HOW OFTEN DO YOU BRUSH?

FLOSS?

USE OTHER AIDS?

ARE YOU HAPPY WITH THE APPEARANCE OF YOUR TEETH?

Yes No

IF NO, WHY?

WHAT ARE YOUR DENTAL EXPECTATIONS?

NAME OF PREVIOUS DENTIST:

CITY:

STATE:

HOW WOULD YOU RATE YOUR PREVIOUS DENTAL EXPERIENCE?

Nearest Relative

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU?



PHONE:

ADDRESS:

CITY:

STATE:

ZIP: