

# Patient History Information

## Patient Information (CONFIDENTIAL)

Date \_\_\_\_\_  
SS# \_\_\_\_\_  
Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Home Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Email \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Do you prefer to receive calls at your:  Home  Work  Cell Phone  
Check Appropriate Box:  Minor  Single  Married  Divorced  Widowed  Separated  
If student, Name of School/College \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  Full Time  Part Time  
Patient or Parent/Guardian's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Spouse or Parent/Guardian's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_  
Person to contact in case of emergency \_\_\_\_\_ Phone \_\_\_\_\_  
For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.  
 Cash  Personal Check  Credit Card  VISA  MasterCard  Discover  Amex

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## Insurance Information

Name of Subscriber \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS# \_\_\_\_\_ Date Employed \_\_\_\_\_  
Name of Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy/ID # \_\_\_\_\_  
Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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**Your medical history is important to the treatment you will receive. Therefore, it is important that you respond to each question honestly and completely. (Please circle your responses)**

Please describe your current health:      Excellent      Good      Fair      Poor

Please describe the symptoms you are currently having today: \_\_\_\_\_

Have there been any changes in your general health in the past year?      Yes      No  
If yes, please describe: \_\_\_\_\_

Are you now under a physician's care for a particular problem at this time?      Yes      No  
If yes, why? \_\_\_\_\_ Date of last physical exam \_\_\_\_/\_\_\_\_/\_\_\_\_

Have you ever been hospitalized or had a serious illness?      Yes      No  
If yes, why? \_\_\_\_\_

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## Patient Medical History

Do you have or have you ever had:  
(Please circle any/all that may apply)

Congenital Heart Disease, Cardiovascular Disease, Heart Attack, Heart Murmur, Coronary Artery Disease, Angina, High/Low Blood Pressure, Stroke, Irregular Heartbeat, Heart Surgery, Cardiac Pacemaker, Mitral Valve Prolapse?	Yes	No	Lung Disease, Asthma, Emphysema, COPD, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing, Easily Winded?	Yes	No
			Glaucoma?	Yes	No
Joint Replacement or Implants placed anywhere in the body (Heart Valve, Pacemaker, Hip, Knee)?	Yes	No	Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? Sexually Transmitted Disease? AIDS? HIV Infection?	Yes	No
Kidney Disease or Kidney Failure, requiring Dialysis?	Yes	No	Liver Disease (Jaundice, Hepatitis A, B, or C)?	Yes	No
Thyroid Problem?	Yes	No	Diabetes?	Yes	No
Stomach Ulcers or Colitis?	Yes	No	Arthritis?	Yes	No
Radiation to the head or neck for cancer treatment?	Yes	No	Significant Weight Loss or Gain?	Yes	No
Osteoporosis or Osteopenia?	Yes	No	Seizures, Convulsions, Epilepsy, Fainting or Dizziness?	Yes	No
Sinus or Nasal problems? Allergies?	Yes	No			

Any other disease, Chemotherapy or Transplant Operation? Cancer? Leukemia? Yes No  
If so, where? \_\_\_\_\_, and when was the date of your last treatment? \_\_\_\_\_

Do you have any other disease, condition or problem not listed above that you think the doctor should know about? Yes No  
If yes, please explain: \_\_\_\_\_

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## Family Medical History

Do you have a family history of any of the following? (If yes, indicate the relationship)

Diabetes?	Yes	No	Relationship _____	Cancer?	Yes	No	Relationship _____
Heart Disease?	Yes	No	Relationship _____	Bleeding Problems?	Yes	No	Relationship _____
Tumors?	Yes	No	Relationship _____	Lung Disease?	Yes	No	Relationship _____

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## Female Patients

Are you pregnant, or is there any chance you might be pregnant? Yes No If Yes, how far along \_\_\_\_\_  
and expected due date \_\_\_\_\_

Are you nursing? Yes No  
Are you taking oral contraceptives Yes No

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## Medications

(If yes, please LIST ALL medications and indicate why you are taking it)

Are you taking any of the following:

Antibiotics? _____	Yes	No	Aspirin or drugs such as Motrin, Aleve, Ibuprofen? _____	Yes	No
Anticoagulants (Blood Thinners)? _____	Yes	No	Insulin or Oral Anti-diabetic drugs? _____	Yes	No
Heart Drugs? _____	Yes	No	High Blood Pressure medications? _____	Yes	No
Steroids (Cortisone, Prednisone, etc.)? _____	Yes	No	Bisphosphonates ( Fosamax, Boniva, Actonel), Antiangiogenic and/or Antiresorptive medications for Osteoporosis, Multiple Myeloma or other Cancers? If yes, list drugs used and time of use.	Yes	No
Anti-anxiety Agents, Sedative-hypnotics and Antidepressants _____					
Prescription Pain Medication?	Yes	No	_____		

Please list any other medications you have taken or are currently taking not listed above including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals: \_\_\_\_\_

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## Allergies

Are you allergic to or have you had an adverse reaction to: (If yes, please list and/or circle)

Latex? (gloves used in dental office) _____	Yes	No	Codeine or other pain killers? _____	Yes	No
Food products? _____	Yes	No	Aspirin, Motrin, Aleve, or Ibuprofen? _____	Yes	No
Sedatives, Barbiturates? _____	Yes	No	Penicillin, Sulfa Drugs, or other antibiotics? _____	Yes	No

Have you or an immediate family member had any problem associated with Local Anesthesia, General Anesthesia, and/or Intravenous Sedation? Yes No If yes, which anesthetic? \_\_\_\_\_ Relationship? \_\_\_\_\_

Other drug allergies not listed above: (Iodine, Any Metals) \_\_\_\_\_

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## Social History

Have you ever smoked or chewed tobacco? Yes No If yes, for how long? \_\_\_\_\_

Have you ever sought professional care or been hospitalized for:

Drug Abuse?	Yes	No	Do you use:		
Emotional Disorders?	Yes	No	Alcohol?	Yes	No
Alcoholism?	Yes	No	Marijuana?	Yes	No
			Recreational Drugs?	Yes	No

How often? \_\_\_\_\_  
How often? \_\_\_\_\_  
How often? \_\_\_\_\_

# Dental History

Name of Previous Dentist and Location \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

- |  |        |   |        |
|--|--------|---|--------|
| 1. Have you had any adverse effects from dental treatment?     | Yes No | 10. Do you clench or grind your teeth?          | Yes No |
| 2. Do you wish to talk to the doctor privately about anything? | Yes No | 11. Do you bite your lips or cheeks frequently? | Yes No |
| 3. Do your gums bleed while brushing or flossing?              | Yes No | 12. Have you ever had any difficult             | Yes No |
| 4. Are your teeth sensitive to hot or cold liquids/foods?      | Yes No | extractions in the past?                        |        |
| 5. Are your teeth sensitive to sweet or sour liquids/foods?    | Yes No | 13. Have you ever had any prolonged bleeding    | Yes No |
|  |        | following extractions?                          |        |
| 6. Do you feel pain to any of your teeth?                      | Yes No | 14. Have you had any orthodontic treatment?     | Yes No |
| 7. Do you have frequent headaches?                             | Yes No | 15. Do you wear dentures or partials?           | Yes No |
| 8. Frequent or recurring mouth sores?                          | Yes No |   |        |
| 9. Have you ever experience any of the following               |        |   |        |
| problems in your jaw?  |        |   |        |
| Clicking   | Yes No |   |        |
| Pain (joint, ear, side of face)                                | Yes No |   |        |
| Difficulty in opening or closing                               | Yes No |   |        |
| Difficulty in chewing  | Yes No |   |        |

I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible. To the best of my knowledge, the above information is complete and correct.

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

\_\_\_\_\_  
Signature of patient (or parent/guardian if minor)

\_\_\_\_\_  
Date

**Doctor's Comments** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_