

DENTAL HEALTH HISTORY

- CONFIDENTIAL -

PATIENT INFORMATION AND HEALTH HISTORY

Today's Date _____

Patient's Name _____ Sex: M F Birth date _____ Age _____

Home Address _____ City _____ State _____ Zip _____

Occupation _____ Employer _____ How long employed? _____

Cell Phone # _____ Home Phone # _____ Wk. Phone # _____

Are you a full time student? Yes No Soc. Sec. # _____

If Patient is a minor we need: Mother's Birth date _____ Father's Birth date _____

Spouse's (Parent's) Employer _____ Spouse's Soc. Sec. # _____ Wk. Phone _____

Referred to us by: _____ Email Address: _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____

Insurance Co. _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec. # _____

Group # _____ Local # _____

If you have double dental insurance coverage
complete this for the second coverage.

Insured's Name _____

Insurance Co. _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec. # _____

Group # _____ Local # _____

DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____

Address _____

Date of last dental care: _____ Date of last dental x-rays _____

Check (✓) if you have had problems with any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Sensitivity to Hot |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Loose Teeth or Broken Fillings | <input type="checkbox"/> Sensitivity to Sweets |
| <input type="checkbox"/> Clicking or Popping Jaw | <input type="checkbox"/> Periodontal Treatment | <input type="checkbox"/> Sensitivity When Biting |
| <input type="checkbox"/> Food Collection Between Teeth | <input type="checkbox"/> Sensitivity to Cold | <input type="checkbox"/> Sores or Growths In Your Mouth |

How often do you floss? _____ How often do you brush? _____

- PLEASE COMPLETE OTHER SIDE -

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Have you had any serious illnesses or operations? _____ If yes, describe _____

Have you ever had a blood transfusion? Yes No If yes, give approximate dates _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking Birth Control Pills? Yes No

Do You Pre-Medicate? (pins, plates, screws, joint replacements, heart problems) _____

Check (✓) if you have had problems with any of the following:

- | | | |
|---|--|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Artificial Heart, Valves | <input type="checkbox"/> Headaches | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Back Problems | Describe _____ | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Swelling of Feet and Ankles |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Cough (persistent) | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cough Up Blood | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nerve Problems | <input type="checkbox"/> Venereal Disease |

MEDICATIONS

List medications you are currently taking: _____

Pharmacy Name _____ Phone _____

ALLERGIES

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Barbiturates (Sleeping pills) | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> _____ |

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Signature _____