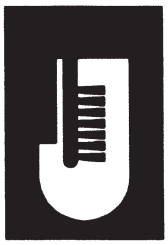

WELCOME

DATE_____ PATIENT'S NAME_____

HOME ADDRESS_____

MAILING ADDRESS_____

HOME PHONE #_____ S.S.#_____ LICENSE #_____

CELL PHONE # _____ EMAIL ADDRESS _____

BIRTHDAY____/____/____/ AGE_____ GUARDIAN(if patient is a minor)_____

EMERGENCY CONTACT_____ PHONE #_____

EMPLOYER_____ OCCUPATION_____ YRS EMPLOYED_____

EMPLOYER ADDRESS_____ PHONE#_____

SPOUSE'S NAME_____

SPOUSE'S EMPLOYER_____

EMPLOYER ADDRESS_____

SPOUSE'S S.S#_____ BIRTHDATE____/____/____ WORK PHONE#_____

INSURED'S NAME_____ S.S#_____

RELATION_____ DATE OF BIRTH _____

INSURANCE COMPANY_____ GROUP #_____

INSRANCE COMPANY ADDRESS_____ PHONE #_____

DO YOU HAVE DUAL COVERAGE? yes_____ no_____ if yes: PLEASE COMPLETE THE FOLLOWING INFO:

SECONDARY INSURANCE NAME_____ INSURED'S S.S.# _____

RELATION_____ DATE OF BIRTH _____

INSURED'S EMPLOYER_____ PHONE#_____

INSURED'S COMPANY ADDRESS_____ PHONE#_____

WHOM MAY WE THANK FOR REFERRING YOU?_____

* We invite you to discuss with us any questions regarding your services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
* Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
* I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
* I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

SIGNATURE _____ DATE _____

Circle one: Adult patient Parent or Guardian Spouse

CONFIDENTIAL HEALTH HISTORY

Patient Name: _____ **Date of Birth:** _____

I. CIRCLE APPROPRIATE ANSWER

Yes No Is your general health good? If NO, explain: _____

Yes No Has there been a change in your health within the last year? If YES, explain: _____

Yes No Have you gone to the hospital, emergency room, or had a serious illness in the last three years?
If YES, explain: _____

Yes No Are you being treated by a physician now? If YES, explain: _____
Date of last medical exam _____ Reason for exam _____

Yes No Have you had problems with prior dental treatment? If YES, explain: _____
Date of last dental exam _____ Name of last treating dentist _____

Yes No Are you in pain now? If YES, explain: _____

II. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Circle appropriate answer)

Yes No AIDS / HIV	Yes No Chronic "Postnasal Drip"	Yes No Hepatitis Type: _____	Yes No Respiratory Disease
Yes No Anemia	Yes No Congenital Heart Lesions	Yes No Herpes	Yes No Rheumatic fever
Yes No Arthritis, Rheumatism	Yes No Cortisone Treatments	Yes No High Blood Pressure	Yes No Rubella
Yes No Artificial heart Valves	Yes No Cosmetic Surgery	Yes No Hospitalization	Yes No Seizures
Yes No Artificial Joints	Yes No Diabetes	Yes No Jaw Pain	Yes No Scarlet Fever
Yes No Asthma	Yes No Diabetes-Family History	Yes No Kidney or Bladder Disease	Yes No Sexual Transmitted
Yes No Back Problems	Yes No Do you wear contact lenses?	Yes No Liver Disease	Disease
Yes No Bleeding abnormally, with	Yes No Eating Disorders	Yes No Low Blood Pressure	Yes No Skin Disease
extractions or surgery	Yes No Eye Disease	Yes No Measles	Yes No Stomach problems
Yes No Blood Disease	Yes No Emphysema	Yes No Meningitis	Yes No Stroke
Yes No Bronchitis	Yes No Epilepsy	Yes No Mitral Valve Prolapse	Yes No Surgeries
Yes No Cancer	Yes No Glaucoma	Yes No Mumps	Yes No Thyroid Disease
Yes No Canker or Cold Sores	Yes No Hardening of arteries	Yes No Nervous Problems	Yes No Tonsillitis
Yes No Chemical Dependency	Yes No Heart Disease	Yes No Osteoporosis	Yes No Transplants
Yes No Chemotherapy	Yes No Heart Disease-Family History	Yes No Pacemaker	Yes No Tuberculosis
Yes No Chicken Pox	Yes No Heart Attack	Yes No Pertussis	Yes No Tumor
Yes No Chronic Obstructive	Yes No Heart Defects	Yes No Psychiatric care	Yes No Ulcer
Pulmonary Disease (COPD)	Yes No Heart Murmur	Yes No Radiation	Yes No Venereal Disease

If answered YES to any of the above, please explain: _____

_____

III. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Circle appropriate answer)

Yes No Aspirin	Yes No Food	Yes No Nitrous oxide	Yes No Valium
Yes No Codeine	Yes No Latex	Yes No Penicillin	Yes No Vicodin
Yes No Darvon	Yes No Local anesthetic	Yes No Percodan	Yes No Other _____
Yes No Demerol	(Novacaine or Xylocaine)	Yes No Sulfa	_____
Yes No Erythromycin	Yes No Metal	Yes No Tetracycline	_____

I V. MEDICAL UPDATES

I have reviewed my health history and confirm that it accurately states past and present conditions.

Date	B.P.	Patient Signature	Changes To Health History/Medication	Dr. Signature

DOCTOR'S COMMENTS (For Office Use Only)

_____

_____

V. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (Circle appropriate answer)

Yes No Blood in stools	Yes No Diarrhea or constipation	Yes No Frequent urination	Yes No Runny nose
Yes No Blood in urine	Yes No Difficulty swallowing	Yes No Frequent vomiting	Yes No Shortness of breath
Yes No Blurred vision	Yes No Difficulty urinating	Yes No Headaches	Yes No Sinus problems
Yes No Body aches	Yes No Dizziness	Yes No Jaundice	Yes No Skin rash/blisters
Yes No Bruise easily	Yes No Dry mouth	Yes No Joint pain or stiffness	Yes No Sore throat
Yes No Chest pain (angina)	Yes No Excessive thirst	Yes No Malaise	Yes No Stiff neck, mental changes
Yes No Cough, persistent or bloody	Yes No Fainting spells	Yes No Nausea	Yes No Swollen ankles or feet
Yes No Coughing spasms	Yes No Fatigue	Yes No Night sweats	Yes No Swollen glands
Yes No Coughing up blood	Yes No Fever	Yes No Ringing in ears	Yes No Unexplained weight loss

If answered YES to any of the above, please explain: _____

_____

_____

VI. HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS? (Circle appropriate answer)

Yes No Recreational drugs	Yes No Tobacco in any form	Yes No Antibiotics
Yes No Over-the-counter medicines	Yes No Alcohol	Yes No Supplements
Yes No Weight loss medications	Yes No Bisphosphonate (Fosamax)	Yes No Aspirin

If answered YES to any of the above, please explain: _____

_____

_____

VII. LIST ALL CURRENT MEDICATIONS (INCLUDING DOSAGE)

☐ none

_____

_____

_____

VIII. WOMEN ONLY (Circle appropriate answer)

Yes No Are you or could you be pregnant? If YES, what month? _____

Yes No Are you nursing?

Yes No Are you taking birth control pills?

Yes No Do you, or have you ever taken biophosphonates? (ie: Fosamax, Boniva)

If answered YES to any of the above, please explain: _____

_____

IX. ALL PATIENTS (Circle appropriate answer)

Yes No Do you currently have or have you had any diseases or medical problems NOT listed on this form? If YES, explain: _____

_____

Yes No Have you ever been pre-medicated for dental treatment? If YES, give reason: _____

Yes No Have you ever taken Fen-phen? If YES, when: _____

Yes No Do you, or have you ever smoked? If YES, when: _____

Yes No Do you snore? If YES, explain: _____

Yes No Are you tired during the day? If YES, explain: _____

Yes No Are there any issues or conditions that you would like to discuss with the dentist in private?

The practice of dentistry involves treating the patient as a whole. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be required prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature: X _____ **Date:** _____

Physician's Name: _____ **Phone Number:** _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of the form.

X_____ _____ **X**_____ _____

Signature of Patient (Parent or Guardian) **Date** **Signature of Dentist** **Date**