DENTAL HEALTH HISTORY

(Confidential)

PATIENT INFORMATION

First _____ MI ___ Last _____ DOB _____ Phone # _____

Mailing Address_____ City _____ State _____ Zip _____

Emergency Contact & Phone _____ Parent's/Guardian's Name _____

Who May We Thank for Referring You to our Office? _____ Reason for this Visit _____

Previous Dentist _____ Last Visit_____ Were X-rays Taken? ___ Yes ___No

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Are you under medical treatment now? _____ Have you had any serious illnesses or operations?_____

If Yes, describe _____

Check if you have or have had any of the following:

- ☐ A.I.D.S / HIV Positive
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artifiical Joints _____
- ☐ Asthma / Shortness of breath
- ☐ Back Problems
- ☐ Cancer _____
  - ☐ Chemotherapy
  - ☐ Radiation Treatment
- ☐ Chemical Dependency
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Chronic
- ☐ COPD
- ☐ Crohn's Disease
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
  - ☐ Type 1
  - ☐ Type 2
  - ☐ Last A1C _____
- ☐ Emphysema
- ☐ Epilepsy / Seizures
- ☐ Fainting / Dizzy Spells
- ☐ Glaucoma
- ☐ Headaches / Migraines
- ☐ Heart Problems
  - ☐ Artificial Heart Valves
  - ☐ Attack
  - ☐ Mitral Valve Prolapse
  - ☐ Murmer
- ☐ Pacemaker
- ☐ Other _____
- ☐ Hemophilia / Blood Disease
- ☐ Hepatitis A B C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ M.S.
- ☐ Nervous / Anxiety Problems
- ☐ Pacemaker
- ☐ Parkinsons
- ☐ Psychiatric Care
- ☐ Respiratory Disease
- ☐ Rheumatic Fever / Scarlet Fever
- ☐ Skin Rash / Psoriasis
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Disease
- ☐ Tobacco Habit
  - How much per day _____
  - How many years _____
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Use of Blood Thinning Medications
  - Last INR _____
- ☐ Other _____ _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

MEDICATIONS

PHARMACY NAME: _____

List medications you are currently taking: _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

ALLERGIES

- ☐ Aspirin
- ☐ Barbituates (Sleeping pills)
- ☐ Codeine
- ☐ Latex Rubber, Metals
- ☐ Peanut Butter
- ☐ Other _____
- ☐ Local Anesthetic
- ☐ Hay Fever
- ☐ Penicillin
- ☐ Sulfa
- ☐ Nuts / Fruits

_____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____ Insured's Employer _____ Phone _____

Date of Birth _____ Insured's Soc. Sec. # _____ Insurance Co. _____

Group # _____ Local # _____ I.D. No. _____

SIGNATURE

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

Date _____ Signature _____