New Patient Health History Form

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Patient Information

Patient's Name:_____
Last First Middle Initial Nickname

Address:_____

Home Phone:_____ Work:_____ Cell:_____

Email address:_____Birthdate:_____Social Security #:_____

Employer:_____ Occupation:_____

____ I would like to receive correspondence via email

Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed ___ Separated

Spouse's Name (if applicable):_____

Employer:_____ Occupation:_____

Social Security #:_____Birthdate:_____

Cell Phone:_____Work Phone:_____

Whom may we thank for referring you to our office?:_____

Responsible Party

Person responsible for account:_____ Relationship to patient:_____

Dental Insurance Information:

Do you have Dental Insurance: □ Yes □ No (if yes please fill out the following information)

Employee Name:_____ Employee Name(Secondary):_____

Birthdate:_____ Birthdate:_____

SS # (required):_____ SS # (required):_____

Insurance Co.:_____ Insurance Co.:_____

Ins Phone:_____ Ins Phone:_____

Group #:_____ Group #:_____

Patient Medical History

Physician:_____ Office Phone:_____ Last exam:_____

Please circle Yes or No (if Yes fill in details)

Yes No 1.) Are you under medical treatment now?

Yes No 2.) Have you ever been hospitalized for any surgical operations or serious illness within the last 5 years?
If yes, please explain:_____

Yes No 3.) Are you currently taking any medications?
Including, non-prescription medicine? _____
_____

Yes No 4.) Have you ever taken Fen-Phen/Redux?

Yes No 5.) Have you ever taken Fosamax, Boniva, Actonel or any Cancer medication containing bisphosphonates?

Yes No 6.) Have you taken Viagra, Revatio, Cialis or Levitra in last 24hr?

Yes No 7.) Do you use tobacco? _____ per day _____ how many yrs.

Yes No 8.) Do you use controlled substances?

Yes No 9.) Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks?

Yes No 10.) Are you wearing contacts Lenses?

Yes No 11.) Are you allergic to or have you had any reactions to the following ?

Yes No Local Anesthetics (Novocain)
Yes No Penicillin or any other antibiotics
Yes No Sulfa Drugs
Yes No Barbiturates
Yes No Sedatives
Yes No Iodine
Yes No Aspirin
Yes No Any metals (nickel, mercury, ect)
Yes No Latex Rubber
Yes No Other (please list)_____

12.) Women Only:

1. Are you pregnant or thinking you may be? Yes No
2. Are you nursing? Yes No
3. Are you taking oral contraceptives? Yes No

13.) Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	___	___	Heart Disease	___	___	Chest Pains	___	___
Heart Attack	___	___	Cardiac Pacemaker	___	___	Easily Winded	___	___
Rheumatic Fever	___	___	Heart Murmur	___	___	Stroke	___	___
Swollen Ankles	___	___	Angina	___	___	Hay Fever / Allergies	___	___
Fainting / Seizures	___	___	Frequently Tired	___	___	Tuberculosis	___	___
Asthma	___	___	Anemia	___	___	Radiation Therapy	___	___
Low Blood Pressure	___	___	Emphysema	___	___	Glaucoma	___	___
Epilepsy / Convulsions	___	___	Cancer	___	___	Recent Weight Loss	___	___
Leukemia	___	___	Arthritis	___	___	Liver Disease	___	___
Diabetes	___	___	Joint Replacement/Implant	___	___	Heart Trouble	___	___
Kidney Diseases	___	___	Hepatitis / Jaundice	___	___	Respiratory Problems	___	___
AIDS or HIV Infection	___	___	Sexually Transmitted Disease	___	___	Mitral Valve Prolapse	___	___
Thyroid Problem	___	___	Stomach Trouble / Ulcers	___	___	Other _____	___	___

Authorization and Release

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 authorized 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 payments of all services rendered on my behalf or my dependents.

X_____ _____

Signature of patient (or parents/guardian if minor) Date

Patient Dental History

Patient's name:_____ Date of Birth:_____

When was your last dental visit_____ What was done then_____

How often did you visit the dentist before then_____

Name of Previous Dentist and Location:_____

Have you had a complete series of dental films (X-Rays) taken? When/Where_____

How often do you brush your teeth a day _____ How often do you floss your teeth_____

Is your drinking water fluoridated _____ Yes _____ No

Yes	No	
___	___	1). Do your gums bleed while brushing or flossing?
___	___	2.) Are your teeth sensitive to hot or cold liquids/foods?
___	___	3). Are your teeth sensitive to sweets or sour liquids/foods?
___	___	4.) Do you feel pain to any of your teeth?
___	___	5). Do you have any sores or lumps in or near your mouth?
___	___	6.) Have you had any head, neck, or jaw injuries?
___	___	7). Have you ever experienced any of the following problems
___	___	Clicking
___	___	Pain (joint, ear, side of face)
___	___	Difficulty in opening or closing
___	___	Difficulty in Chewing
___	___	8.) Do you like your smile?
___	___	9.) Do you have frequent headaches?
___	___	10.) Do you clench or grind your teeth?
___	___	11.) Do you bite your lips or cheeks frequently?
___	___	12.) Have you ever had any difficult extractions in the past?
___	___	13.) Have you ever has any prolonged bleeding after extractions?
___	___	14.) Have you had any orthodontic treatment?
___	___	15.) do you wear Denture or Partials? Since when _____
___	___	16.) Have you ever received oral hygiene instructions regarding the care of your teeth and gums?

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered.

X_____ _____

Signature of patient (or parents/guardian if minor) Date