

Health History Form

Date _____

Patient Name _____ Height _____ Weight _____ Birth Date _____ Age _____

Address _____ City _____ State _____ Zip _____ Sex: M F

Home() _____ Work() _____ Cell() _____ SS# _____

Best time and place to reach you _____

Married Widowed Single Minor Separated Divorced Other

Occupation _____ Patient's Employer _____ Employer Phone() _____

Spouse's Name _____ Spouse's Birth Date _____

Spouse's Work() _____ Spouse's Cell () _____

In Case of Emergency, Contact Name _____

Relationship _____ Home() _____ Work() _____

Whom May We Thank For Referring You? _____

Children/Ages _____

Dental Information

Have you had any problems associated with previous dental treatment? Y/N

Are you currently experiencing dental pain or discomfort? Y/N

Name of last Dentist _____

Date of your last dental exam: _____ Date of last dental x-rays: _____

What is the reason for your dental visit today? _____

How do you feel about your smile? _____

Do you have or have your had any of the following?

- | | |
|---|--|
| <input type="checkbox"/> Gums bleed when you Floss | <input type="checkbox"/> Had orthodontic (braces) treatment |
| <input type="checkbox"/> Earaches/Neck Pain | When? _____ |
| <input type="checkbox"/> Cold, hot, sweet or pressure sensitivity | <input type="checkbox"/> Clicking, popping or jaw discomfort |
| <input type="checkbox"/> Floss Catch between teeth | <input type="checkbox"/> Dentures or Partials |
| <input type="checkbox"/> Dry Mouth | <input type="checkbox"/> Ulcer or sores in your mouth |
| <input type="checkbox"/> Had any periodontal/gum treatment | <input type="checkbox"/> Head or mouth injury |
| When? _____ | When? _____ |
| <input type="checkbox"/> Brux (grind) Teeth | |

Medical Information

Physicians Name: _____ **Phone:** () _____

Address/City/State/Zip: _____

Are you in good health? ___ Yes ___ No **Date of last physical exam** _____

Are you now under care of a physician? ___ Yes ___ No

If yes, what condition is being treated? _____

Do you have or have your had any of the following?

- | | | |
|---|--|---|
| <input type="checkbox"/> Actonel/ Risedronate
when _____ | <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Diabetes type? I or II | <input type="checkbox"/> Malnutrition |
| <input type="checkbox"/> Alcoholic Beverages | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Mitral Valve Prolapse |
| How often _____ | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Neurological Disorders |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy or Seizures | _____ |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Organ Transplant |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Excessive Urination | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Pagets disease |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Fosamax/Alendronate
when _____ | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Radiation Treatments |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Recent Weight Loss |
| <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Recurrent |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Attack/Failure | _____ |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever |
| when _____ | <input type="checkbox"/> Heart Pace Maker | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Sleep Disorders |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Unrepaired Cyanotic (CHD) | <input type="checkbox"/> Herpes | <input type="checkbox"/> Swollen Glands in Neck |
| <input type="checkbox"/> Repaired (CHD) in the Last | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tobacco _____ |
| 6 months Any residual | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Thyroid Disease |
| defects? _____ | <input type="checkbox"/> Infective Endocarditis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Yellow Jaundice |

Allergy Information

Please check if you're allergic to any of the following:

- Local anesthetics
- Sulfa drugs
- Codeine/other narcotics

- Hay Fever/Seasonal
- Penicillin/other antibiotics
- Aspirin
- Latex sensitivity
- Barbiturates, sedatives, sleeping pills
- Shellfish, Iodine or red wine
- Other_____

WOMEN ONLY

- Pregnant? Number of weeks?_____
- Birth Control Pills?

Do you have any disease, condition or problem not listed above that you think we should know about?_____

Please list all of the medications you are currently taking. Please include all OTC and Vitamins.

Insurance Information

Will we be filing dental insurance for you Y/N

Subscribers Name_____

Subscribers SS#_____ Subscribers DOB_____

Do you have a secondary insurance that you would like us to file? Y/N

Subscribers Name_____

Subscribers SS#_____ Subscribers DOB_____

Note: Both Doctor and Patient are encouraged to discuss any and all relevant patient issues prior to treatment. I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Patient/Guardian signed a copy after completing it in the patient's chart.

Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: ____/____/____

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Spouse _____

Child(ren) _____

Other _____

Information is not to be released to anyone.

This *Release of Information* will remain in effect until terminated by me in writing.

Messages

Please call my home my work my cell Number: _____

If unable to reach me:

you may leave a detailed message

please leave a message asking me to return your call

The best time to reach me is (day) _____ between (time) _____

Signed: _____ Date: ____/____/____

Witness: _____ Date: ____/____/____