Health History

So we can ensure we are looking after your needs, please review and complete the following questionnaire:

Last name:_____ Date of birth:_____

First name:_____ Social Security number:_____

Preferred name:_____

Address:_____ City: _____

Zip code:_____

Home phone:_____ Work phone:_____

Mobile phone:_____ Email:_____

Employer:_____ Occupation:_____

Recommended by:_____ Phone:_____

Purpose of visit:_____

Name of person responsible for fees (if not self):_____

Dental Insurance Company:_____Phone:_____

Is another member of your family a patient at our office? □ Yes □ No

Have you had any of the following?

1. Heart problems	□ Yes	13. Allergies to anesthetics	□ Yes
2. High/Low blood pressure	□ Yes	14. Allergies to penicillin	□ Yes
3. Artificial joints	□ Yes	15. Allergies to medications	□ Yes
4. Rheumatic fever	□ Yes	16. Allergies to latex	□ Yes
5. Circulatory problems	□ Yes	17. Allergies to metal	□ Yes
6. Radiation treatment	□ Yes	18. Diabetes	□ Yes
7. Excessive bleeding	□ Yes	19. Asthma	□ Yes
8. Ulcers (stomach)	□ Yes	20. Hepatitis A B C D E	□ Yes
9. Sinus trouble	□ Yes	21. Epilepsy	□ Yes
10. Tumor history	□ Yes	22. Liver or kidney problems	□ Yes
11. Cold sores/Fever blisters	□ Yes	23. Anemia or other blood disorders	□ Yes
12. Immune disorders	□ Yes		

Are you taking any bisphosphonate/osteoporosis drugs? (Fosomax, Actonel, Boniva, etc)
If 'yes', please list: _____

Are you currently taking any prescription or OTC medications? □ Yes □ No
If 'yes', please list: _____

Have you had any of the following?

24. Does your jaw 'click' or hurt?	□ Yes	31. Do you smoke?	□ Yes
25. Do you feel you grind your teeth?	□ Yes	32. Do you think you have occasional bad breath?	□ Yes
26. Have you ever had orthodontic treatment?	□ Yes	33. Do your gums ever bleed when you brush?	□ Yes
27. Do you wear a dental night guard?	□ Yes	34. Do you experience sensitivity with hot/cold?	□ Yes
28. Have you ever had periodontal (gum) treatment?	□ Yes	35. Do your teeth ever hurt when you bite hard?	□ Yes
29. Have you ever had your bite adjusted?	□ Yes	36. Does floss ever tear between your teeth?	□ Yes
30. Do you bite your lips or cheeks often?	□ Yes	37. Does food get jammed between your teeth?	□ Yes

Other notes:_____

_____

_____

The name/location of your physician:_____

Phone:_____

Are you pregnant? □ Yes Due date:_____

How long since your last dental appointment?_____

How often do you have dental examinations?_____

Previous dental x-rays were taken: □ Less than a year □ Longer than a year

Consent for Treatment

I hereby authorize the dentist or designated staff to take x-rays, study models, photographs, and other diagnostic aides deemed appropriate by the dentist to make a thorough diagnosis. Upon such diagnosis, I authorize the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand I can ask for a complete recital of any possible complications. I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

Patient's Signature:_____ Date:_____

Parent/Responsible Party's Signature:_____ Relationship to Patient:_____