In order to submit this form, you should open it with Adobe Acrobat Reader.

Health History

Name

First Name | Middle Name | Last Name

Social Security

E-mail

example@example.com

Home Phone:

Area Code | Phone Number

Cell Phone:

Area Code | Phone Number

Address:

Street Address

Street Address Line 2

City | State / Province

Postal / Zip Code

Sex

- ☐ Male
- ☐ Female

Date of Birth

Age

Marital Status

Patient Employer/School

Occupation

Employer/School Address:

Street Address

Street Address Line 2

City | State / Province

Postal / Zip Code

Employer/School Phone

Area Code | Phone Number

Driver's License

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV Positive

- ○ Yes
- ○ No

Alzheimer's Disease

- ○ Yes
- ○ No

Anaphylaxis

- ○ Yes
- ○ No

Anemia

- ○ Yes
- ○ No

Angina

- ○ Yes
- ○ No

Arthritis/Gout

- ○ Yes
- ○ No

Artificial Heart Valve

- ○ Yes
- ○ No

Artificial Joint

- ○ Yes
- ○ No

Asthma

- ○ Yes
- ○ No

Blood Disease

- ○ Yes
- ○ No

Blood Transfusion

- ○ Yes
- ○ No

Breathing Problem

- ○ Yes
- ○ No

Bruise Easily

- ○ Yes
- ○ No

Cancer

- ○ Yes
- ○ No

Chemotherapy

- ○ Yes
- ○ No

Chest Pains

- ○ Yes
- ○ No

Cold Sores/Fever Blisters

- ○ Yes
- ○ No

Congenital Heart Disorder

- ○ Yes
- ○ No

Convulsions

- ○ Yes
- ○ No

Cortisone Medicine

- ○ Yes
- ○ No

Diabetes

- ○ Yes
- ○ No

Drug Addiction

- ○ Yes
- ○ No

Easily Winded

- ○ Yes
- ○ No

Emphysema

- ○ Yes
- ○ No

Epilepsy or Seizures

- ○ Yes
- ○ No

Excessive Bleeding

- ○ Yes
- ○ No

Excessive Thirst

- ○ Yes
- ○ No

Fainting Spells/Dizziness

- ○ Yes
- ○ No

Frequent Cough

- ○ Yes
- ○ No

Frequent Headaches

- ○ Yes
- ○ No

Genital Herpes

- ○ Yes
- ○ No

Glaucoma

- ○ Yes
- ○ No

Hay Fever

- ○ Yes
- ○ No

Heart Attack/Failure

- ○ Yes
- ○ No

Heart Murmur

- ○ Yes
- ○ No

Heart Pace Maker

- ○ Yes
- ○ No

Heart Trouble/Disease

- ○ Yes
- ○ No

Hemophilia

- ○ Yes
- ○ No

Hepatitis A

- ○ Yes

○ No

Hepatitis B or C

- ○ Yes
- ○ No

Herpes

- ○ Yes
- ○ No

High Blood Pressure

- ○ Yes
- ○ No

Hives or Rash

- ○ Yes
- ○ No

Hypoglycemia

- ○ Yes
- ○ No

Irregular Heartbeat

- ○ Yes
- ○ No

Kidney Problems

- ○ Yes
- ○ No

Leukemia

- ○ Yes
- ○ No

Liver Disease

- ○ Yes
- ○ No

Low Blood Pressure

- ○ Yes
- ○ No

Lung Disease

- ○ Yes
- ○ No

Mitral Valve Prolapse

- ○ Yes
- ○ No

Pain in Jaw Joints

- ○ Yes
- ○ No

Radiation Treatments

- ○ Yes
- ○ No

Recent Weight Loss

- ○ Yes
- ○ No

Renal Dialysis

- ○ Yes
- ○ No

Rheumatic Fever

- ○ Yes
- ○ No

Rheumatism

- ○ Yes
- ○ No

Scarlet Fever

- ○ Yes
- ○ No

Shingles

- ○ Yes
- ○ No

Sinus Trouble

- ○ Yes
- ○ No

Stomach/Intestinal Disease

- ○ Yes
- ○ No

Stroke

- ○ Yes
- ○ No

Swelling of Limbs

- ○ Yes
- ○ No

Thyroid Disease

- ○ Yes
- ○ No

Tonsillitis

- ○ Yes
- ○ No

Tuberculosis

- ○ Yes
- ○ No

Tumors or Growths

- ○ Yes
- ○ No

Ulcers

- ○ Yes
- ○ No

Venereal Disease

- ○ Yes
- ○ No

Whom may we thank for referring you?

In case of emergency who should be notified?

Phone Number

Area Code

Phone Number

Medications

List any medications you are currently taking and the correlating diaganosis:

Pharmacy name

Phone

Allergies

Are you allergic to

- ☐ Aspirin
- ☐ Barbiturates (Sleeping pills)
- ☐ Codeine
- ☐ Latex
- ☐ Local Anesthetic

- [ ] Penicillin
- [ ] Sulfa
- [ ] _____

Primary Dental Insurance

Person Responsible for Account

First Name | Middle Name | Last Name

Relation to Patient

Social Security #

Date of Birth

Contact Number:

Area Code | Phone Number

Address:

Street Address

Street Address Line 2

City | State / Province

Postal / Zip Code

Person Responsible Employed by

Occupation

Business Address

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Business Phone

Area Code

Phone Number

Insurance Company

Contract

Group

Subscriber

Names of other dependents covered under this plan

Secondary Dental Insurance

Is patient covered by additional insurance?

- ○ Yes
- ○ No

Subscriber Name

Date of Birth

Relation to Patient

Phone Number

Area Code | Phone Number

Address

Street Address

Street Address Line 2

City | State / Province

Postal / Zip Code

Subscriber Employed

Business Phone

Phone Number

Area Code

Insurance Company

Social Security #

Contract #

Group #

Subscriber #

Names of other dependents covered under this plan

Dental History

Reason's for today's visit

Date of Last Dental Care

Former Dentist

Date of Last X-Rays

Address

Street Address

Street Address Line 2

City | State / Province

Postal / Zip Code

Check if you have had problems with any of the following:

- ○ Bad Breath
- ○ Bleeding Gums
- ○ Blisters on lips or mouth
- ○ Burning sensation on tongue
- ○ Chew on one side of mouth
- ○ Cigarette, pipe or cigar smoking
- ○ Clicking or popping jaw
- ○ Dry mouth

- Fingernail biting
- Food collection between the teeth
- Foreign objects
- Grinding Teeth
- Gums swollen or tender
- Jaw pain or tiredness
- Lip or cheek biting
- Loose teeth or broken fillings
- Mouth breathing
- Mouth pain, brushing
- Orthodontic treatment
- Pain around ear
- Periodontal Treatment

- ○ Sensitivity to cold
- ○ Sensitivity to heat
- ○ Sensitivity to sweets
- ○ Sensitivity when biting
- ○ Sores or growths in your mouth

How often do you floss?

How often do you brush?

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. **Thank you for answering the following questions.**

Medical History

For any "Yes" answers, please explain below

	Yes	No
Are you under a physician's care now?	○	○
Have you ever been hospitalized or had a major operation?	○	○
Have you ever had a serious head or neck injury?	○	○

Do you use tobacco?	○	○
Do you use controlled substances?	○	○
Are you taking any medications, pills or drugs?	○	○
Are you allergic to any of the following? Aspirin, Penicillin, Codeine, Acrylic, Metal, Latex, Local Anesthetics. If yes, please explain below.	○	○

If you answered yes to above, please explain:

For Women:

	Yes	No
Are you pregnant or trying to get pregnant?	○	○
Taking oral contraceptives?	○	○
Are you nursing?	○	○

Do you have, or have you had, any of the following? If you have had a serious illness not listed, check OTHER and explain.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect informatior can be dangerous to my (or patients) health. It is my responsibility to inform the dental office of any changes in medical status. SIGNATURE OF PATIENT, PARENT, or GUARDIAN.

Date