HOLEHOUSE
CENTER FOR COMPLETE DENTISTRY

3700 Winter Garden Vineland Road, Winter Garden, Fl. 34787 ~ 407.654.1296

Date _____

Name _____ I preferred to be called _____

Address _____ City _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth _____ Social Security #_____

Minor___ Single___ Married___ Divorced___ Separated___ Other___

Email _____ Occupation _____

In case of emergency, please contact: Name & Phone _____

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

Dental Insurance Information

Who is responsible for this account? _____ Relationship to Patient _____

Birth date of policy owner _____ Their Social Security # _____

Insurance Co._____ Phone # _____

Assignment & Release: I certify that I and/or my dependant(s) have insurance coverage with and assign directly to Dr. Holehouse all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

_____ _____

Signature of Patient Date

Dental History

Why have you come to see us today? _____

Do you have specific area(s) causing you discomfort? _____

When was the last time you saw a dentist? _____ Name of previous dentist? _____

How often do you brush? _____ Floss? _____ Do your gums ever bleed? _____

Is your bite comfortable when biting/chewing? _____ Do you feel that you grind your teeth? _____

Does your jaw hurt/feel tired? _____

Have you had any sores/bumps in or near your mouth? _____ If yes, how often/where? _____

If you could easily and safely whiten your teeth, would you be interested? _____

Do you have any old fillings or dental treatment that you are unhappy with? _____

Are your teeth sensitive to Heat, Cold, Sweets, Biting Pressure? _____ Where? _____

Health History

Date of last health care exam: _____ What was this exam for? _____

Are you currently receiving care? __Yes __ No If yes, nature of care: _____

_____

Have you been hospitalized in the past 5 years? __Yes __No If yes, reason _____

_____

Have you ever had a serious head or neck injury?_____ If so, explain _____

Are you currently taking any **medications**? Purpose? Please list _____

_____

Have you ever taken **Phen-fen/Redux**? __Yes __No If yes, Have you made your physician aware of your past use and have you been cleared by an echocardiogram of any heart defects? __Yes __No Comments: _____

_____

Have you ever been under bisphosphonate therapy, taken orally, such as **Actonel** or **Fosamax**? Or taken through an IV, such as **Aredia** or **Zometa**? __Yes __ No If Yes, For what condition, for how long, and when was your last dose? _____

Do you use Tobacco products? __Yes __No If yes, what type and how much: _____

For Women only: Are you pregnant or planning to become pregnant? __Yes __No If yes, due date: _____

Are you nursing? __Yes __No Are you taking oral contraceptives? __Yes __No

Have you ever been premedicated for dental treatment? __Yes __No If yes, why? _____

Are You Allergic to or Have You Had an Adverse Reaction to:

Y N Latex or Rubber products
Y N Local anesthetics
Y N Sedatives
Y N Penicillin
Y N Iodine
Y N Metals
Y N Ibuprofen or Aspirin
Y N Codeine
Y N Other _____

Do You Have or Have You Ever Had: Answer by circling Yes (Y) or No (N)

Y N AIDS,HIV Positive	Y N Chest Pains	Y N Frequent Headache	Y N Irregular Heartbeat	Y N Scarlet Fever
Y N Alzheimer's Disease	Y N Cold Sores/Fever Blisters	Y N **Head Injury**	Y N Kidney Problems	Y N Shingles
Y N Anaphylaxis	Y N Congenital Heart Disorder	Y N Glaucoma	Y N Leukemia	Y N Sickle Cell Disease
Y N Anemia	Y N Convulsions	Y N Hay Fever	Y N Liver Disease	Y N Sinus Trouble
Y N Angina	Y N Cortisone Therapy	Y N Heart Attack/Failure	Y N Low Blood Pressure	Y N Spina Bifida
Y N Arthritis/Gout	Y N **Diabetes Type** _____	Y N **Heart Murmur**	Y N Lung Disease	Y N Stomach/Intestinal Ds.
Y N **Artificial Heart Valve**	Y N Drug Dependency	Y N Heart Pace Maker	Y N **Mitral Valve Prolapse**	Y N Stroke
Y N **Artificial Joint**	Y N Easily Winded	Y N Heart Trouble/Ds.	Y N Pain in Jaw Joint	Y N Swelling of Limbs
Y N Asthma	Y N Emphysema	Y N Hemophilia	Y N Parathyroid Disease	Y N Thyroid Disease
Y N Blood Disease	Y N Epilepsy/Seizures	Y N Hepatitis A	Y N Psychiatric Care	Y N Tonsillitis
Y N Blood Transfusion	Y N Excessive Bleeding	Y N Hepatitis B/C	Y N Radiation Therapy	Y N Tuberculosis
Y N Breathing Problems	Y N Excessive Thirst	Y N Herpes - Oral	Y N Recent Weight Loss	Y N Tumors/Growths
Y N Bruise Easily	Y N Fainting/Dizzy Spells	Y N High Blood Pressure	Y N Renal Dialysis	Y N Ulcers
Y N Cancer	Y N Frequent Cough	Y N Hives/Rash	Y N **Rheumatic Fever**	Y N STD's
Y N Chemotherapy	Y N Frequent Diarrhea	Y N Hypoglycemia	Y N Rheumatism	Y N Yellow Jaundice

Y N Other serious illness not listed above, Explain _____

Please list all names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____
3. _____

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 exam rendered to me or my child during the period of such Dental care to third party payers and/ health practitioners. If my health or medications change, I will inform my doctor at my next appointment.

_____ _____ _____

Signature of Patient Date Signature of Doctor Date