



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 Penicillin | Y N Ibuprofen or Aspirin |
| Y N Local anesthetics        | Y N Iodine     | Y N Codeine              |
| Y N Sedatives                | Y N Metals     | 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 <b>Head Injury</b>   | 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 <b>Diabetes Type</b> _____ | Y N <b>Heart Murmur</b>  | Y N Lung Disease                 | Y N Stomach/Intestinal Ds. |
| Y N <b>Artificial Heart Valve</b> | Y N Drug Dependency            | Y N Heart Pace Maker     | Y N <b>Mitral Valve Prolapse</b> | Y N Stroke                 |
| Y N <b>Artificial Joint</b>       | 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 <b>Rheumatic Fever</b>       | 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