

PATIENT HEALTH HISTORY

An essential part of our approach is a thorough health history. Please fill out this health questionnaire completely even if some of the questions may not seem relevant to your dental health. Your answers are for our records only and will be kept confidential in accordance with applicable laws.

DATE / /

PATIENT INFORMATION					
<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss		FIRST NAME _____	LAST NAME _____	PREFERRED NAME _____	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		/ /	- -		
BIRTH DATE		AGE	SOCIAL SECURITY NUMBER	E-MAIL	
STREET ADDRESS _____			CITY	STATE	ZIP
()		()		Are you a new patient? Yes <input type="checkbox"/> No <input type="checkbox"/>	
HOME PHONE _____		CELLULAR PHONE _____			
BILLING ADDRESS _____			CITY	STATE	ZIP
			Cash <input type="checkbox"/> Check <input type="checkbox"/>		
DRIVERS LICENSE NUMBER _____			Personal Payment Type: Credit Card <input type="checkbox"/>		REFERRED BY _____
EMPLOYER _____			()		
EMERGENCY CONTACT _____			BUSINESS TELEPHONE _____		
NAME		RELATIONSHIP		PHONE	

DENTAL INFORMATION					
Have you noticed any of the following:					
Teeth tender to chew on?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Sensitivity to sweets, hot or cold?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Discomfort in face, head, neck or jaw?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Recurring sore in or around the mouth?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Food caught between your teeth?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Jaw clicking or popping?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Bleeding or sore gums?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Loose teeth?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
			Swelling or lumps in mouth? <input type="checkbox"/> <input type="checkbox"/>		
			Do you need to be sedated for dental visits? <input type="checkbox"/> <input type="checkbox"/>		
			Do you have a removable dental appliance? <input type="checkbox"/> <input type="checkbox"/>		
Reason for this dental visit: _____					
Date of last dental visit: _____ What was done?: _____					
Are you allergic to any of the following?					
Local anesthetic (numbing medication)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Aspirin	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Penicillin	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Codeine or other narcotics	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Sulfa drugs	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Latex	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Valium or other sedatives	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Other (specify): _____		
Have you had any problems with previous dental treatment? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please explain: _____					

INTEREST IN TOOTH WHITENING OR SMILE IMPROVEMENT PROCEDURES			
Are you happy with the appearance of your teeth?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Are you interested in whitening your teeth? Yes <input type="checkbox"/> No <input type="checkbox"/>
Are you interested in straightening your teeth?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If you could change your teeth / smile, what would you change? _____

ADDITIONAL INFORMATION
What are your hobbies or special interests? (For example, sports, self-improvement, education, etc.) _____

FEMALE PATIENTS

Is there a possibility of pregnancy? Yes No Are you nursing? Yes No

Expected delivery date: _____ Are you taking birth control pills? Yes No

NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. If you are taking antibiotics and birth control pills we highly recommend that you consult your physician / gynecologist for assistance regarding additional methods of birth control.

HEALTH HISTORY

Any changes in your general health in the past year? Yes No (explain) _____

Are you presently under the care of a physician? Yes No Date of last visit. _____ If yes, for what are you being treated? _____

Have you had any illness, operation, or been hospitalized in the past five years? Yes No If yes, please describe: _____

Do you consume alcohol or tobacco? Yes No If yes, in what quantities? _____

(_____)
 NAME OF PHYSICIAN PHONE

Medication:

Are you currently taking any of the following?

Please list any medications you are taking:

Any kind of medication, drugs, or pills?	Yes No	<input type="checkbox"/> <input type="checkbox"/>	_____
Blood thinners, i.e. Coumadin, Aspirin, Advil?	Yes No	<input type="checkbox"/> <input type="checkbox"/>	_____
Have you ever taken appetite suppressant drugs such as Fen-Phen (Fenfluramine, Phentermine and Dexfenfluramine)?	Yes No	<input type="checkbox"/> <input type="checkbox"/>	_____
Any natural product, herbal supplement or homeopathic remedy?	Yes No	<input type="checkbox"/> <input type="checkbox"/>	_____

Have you had or do you currently have:

	Yes No		Yes No		Yes No
High blood pressure	<input type="checkbox"/> <input type="checkbox"/>	Infectious Mononucleosis	<input type="checkbox"/> <input type="checkbox"/>	Headaches / migraines	<input type="checkbox"/> <input type="checkbox"/>
Swollen ankles	<input type="checkbox"/> <input type="checkbox"/>	Tuberculosis	<input type="checkbox"/> <input type="checkbox"/>	Eye disease / glaucoma	<input type="checkbox"/> <input type="checkbox"/>
Irregular heart beat	<input type="checkbox"/> <input type="checkbox"/>	Hepatitis, jaundice or liver disease	<input type="checkbox"/> <input type="checkbox"/>	Hay fever / sinus problems	<input type="checkbox"/> <input type="checkbox"/>
Chest pain	<input type="checkbox"/> <input type="checkbox"/>	Kidney disease	<input type="checkbox"/> <input type="checkbox"/>	Facial or head injuries	<input type="checkbox"/> <input type="checkbox"/>
Rheumatic heart disease or fever	<input type="checkbox"/> <input type="checkbox"/>	Are you on dialysis	<input type="checkbox"/> <input type="checkbox"/>	Snoring / sleep apnea	<input type="checkbox"/> <input type="checkbox"/>
Heart murmur	<input type="checkbox"/> <input type="checkbox"/>	Stomach ulcers	<input type="checkbox"/> <input type="checkbox"/>	Chronic fatigue / night sweats	<input type="checkbox"/> <input type="checkbox"/>
Damaged heart valves / mitral valve prolapse	<input type="checkbox"/> <input type="checkbox"/>	Sexually transmitted diseases	<input type="checkbox"/> <input type="checkbox"/>	Fainting spells	<input type="checkbox"/> <input type="checkbox"/>
Heart surgery	<input type="checkbox"/> <input type="checkbox"/>	Do you bruise easily	<input type="checkbox"/> <input type="checkbox"/>	Seizures / epilepsy	<input type="checkbox"/> <input type="checkbox"/>
Heart attack(s)	<input type="checkbox"/> <input type="checkbox"/>	Bleeding tendency / abnormal bleeding	<input type="checkbox"/> <input type="checkbox"/>	Memory disorder	<input type="checkbox"/> <input type="checkbox"/>
Cardiac pacemaker	<input type="checkbox"/> <input type="checkbox"/>	Blood transfusion	<input type="checkbox"/> <input type="checkbox"/>	A tumor, growth or cancer	<input type="checkbox"/> <input type="checkbox"/>
Prosthetic valves / artificial heart valves	<input type="checkbox"/> <input type="checkbox"/>	Blood disorder such as anemia	<input type="checkbox"/> <input type="checkbox"/>	Mental health problems	<input type="checkbox"/> <input type="checkbox"/>
Stroke	<input type="checkbox"/> <input type="checkbox"/>	Diabetes	<input type="checkbox"/> <input type="checkbox"/>	Radiation therapy / chemotherapy	<input type="checkbox"/> <input type="checkbox"/>
Difficult breathing / other lung trouble	<input type="checkbox"/> <input type="checkbox"/>	Thyroid disease	<input type="checkbox"/> <input type="checkbox"/>	History of eating disorders	<input type="checkbox"/> <input type="checkbox"/>
Asthma	<input type="checkbox"/> <input type="checkbox"/>	HIV / AIDS	<input type="checkbox"/> <input type="checkbox"/>	Do you use smoke / chewing tobacco	<input type="checkbox"/> <input type="checkbox"/>
Emphysema	<input type="checkbox"/> <input type="checkbox"/>	Arthritis or joint disease	<input type="checkbox"/> <input type="checkbox"/>	A history of alcohol abuse	<input type="checkbox"/> <input type="checkbox"/>
Bronchitis, chronic cough	<input type="checkbox"/> <input type="checkbox"/>	Artificial joint implants	<input type="checkbox"/> <input type="checkbox"/>	A history of drug abuse	<input type="checkbox"/> <input type="checkbox"/>

Please explain any yes answers above: _____

The information provided by me in this form is correct to the best of my knowledge. 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 completion of this form.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

DATE

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