HODGES FAMILY & COSMETIC DENTISTRY
PATIENT HEALTH HISTORY FORM

In order to help us render the proper dental services to you, would you please kindly answer the following questions? Please note the space provided for remarks for any answers that require clarification or any other information you think we should have. Thank you for your cooperation.

Today's Date: _____/_____/_____

Last Name	First Name	Middle Initial		SSN
Date of Birth	Sex	Height	Weight	Marital Status
Address		Zip Code	E-mail	
Home Phone	Cell Phone		Work Phone	
Occupation	Place of Employment		Driver's License	
Spouse's Name	Spouse's Employer		Spouse's Work Phone	
Dental Insurance	Group #		Subscriber's Name	
Subscriber's Employer	Subscriber's Date of Birth		Subscriber's SSN	
Name of Physician	Physician's Phone			
Emergency Contact Name	Emergency Contact Phone			

How did you find out about our office? ____

MEDICAL HISTORY

Have you ever been treated for the following (please check all that apply)?

- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Pacemaker
- ☐ Mitral Valve Prolapse
- ☐ Prosthetic Heart Valve
- ☐ Heart Surgery
- ☐ Fainting Spells
- ☐ Convulsions
- ☐ Nervous Disorders
- ☐ Mental Disorders
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ High Blood Pressure
- ☐ Rheumatic Fever
- ☐ T.B.
- ☐ Emphysema
- ☐ Artificial Joints
- ☐ Bronchitis
- ☐ Asthma
- ☐ Stroke
- ☐ Cancer/Chemotherapy – Type/Date ____
- ☐ Radiation Treatment – Date ______________________________
- ☐ Seizures
- ☐ Hepatitis
- ☐ Cirrosis
- ☐ Herpes/Fever Blisters
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Arthritis
- ☐ Ulcers
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Anemia
- ☐ HIV/AIDS
- ☐ Leukemia
- ☐ History of Bleeding
- ☐ Venereal Disease
- ☐ Thyroid Disorders
- ☐ Other ____

Are you allergic to? ☐ Penicillin ☐ Codeine ☐ Aspirin ☐ Local injected anesthetics ☐ Latex ☐ Other____

Are you pregnant? ☐ Yes ☐ No If yes, months?______________________________

Please list current medications____

Please list any history of surgical procedures or hospitalization (include dates and reason) ______________________________

____

Have you taken or are you currently taking medications known as bisphosphonates (Zoledronic Acid-Zometa, Pamidronate-Aredia, Fosamax)? If yes, please explain. ____________________

DENTAL HEALTH HISTORY

Please answer all of the following questions:

1) Reason for your visit ____________________
2) When was your last dental visit? ____________________
3) Have you ever had any serious complications associated with a previous dental treatment? Please explain.
____
____
____
4) How often do you brush? ____________________
5) How often do you floss? ____________________
6) What texture toothbrush do you use? ☐ Soft ☐ Medium ☐ Hard ☐ Nylon
7) Do your gums bleed when ☐ Brushing ☐ Flossing
8) Have you ever been treated for periodontal disease (gum disease, pyorrhea)? ____________________
9) Do your gums feel tender or swollen? ☐ Yes ☐ No
10) Do you have dentures, fillings, missing teeth or loose teeth? ☐ Yes ☐ No
Please explain____________________
____
11) Do you gag easily? ☐ Yes ☐ No
12) Do you clench or grind your jaw? ☐ Yes ☐ No
13) Do you smoke? ☐ Yes ☐ No
14) Are you happy with the appearance of your teeth? ☐ Yes ☐ No
15) Have your ever had Botox®- Cosmetic or Juvederm®? ☐ Yes ☐ No
Would you be interested in learning more about these procedures? ☐ Yes ☐ No

I am interested in (please check all that apply):
☐ Whiter teeth
☐ A better smile
☐ Replacing missing teeth
☐ Straightening my teeth
☐ Fixing broken or fractured teeth
☐ Healthier gums
☐ Extracting wisdom teeth
☐ A better bite
☐ Eliminating pain/discomfort
☐ A healthy mouth
☐ Botox®- Cosmetic
☐ Juvederm®
☐ Other____________________

Thank you for completing this form. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help. Our office is committed to exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

CONSENT FOR TREATMENT

This is to certify that I, the undersigned, consent to the performing of dental and oral surgical procedures agreed to be necessary or advisable, including local anesthetic, as indicated. I will assume responsibility for fees associated with dental procedures I agree to.

____________________ ____________________
Patient's Signature Date