Implant and Comprehensive Dentistry

Steven C. Hewett D.D.S.

Health History Form

First Name ____________________________ Last Name _____________________________________

Address ____

City ____ State ____________ Zip ___________

Contact Number ____ Cell Phone _____________________

Email ____

Best time to Contact ______________________________________

Date of Birth _______________________________

Is the address above seasonal? ___________________

If so, please list address ____

Emergency Contact

Name ____

Relationship ____

Contact Number ____

Do you have dental insurance? _____yes ______no

If so, please list information below

Dental Insurance Company ____

ID #____ SS# ____________________________________

Dental Information

When was your last visit with a dentist? ____________________Any procedures performed? If so, explain____

Date of last dental x-rays ___________________________________

Do your gums bleed when you floss or brush? _________________________

Are your teeth sensitive to cold, hot, sweets, or pressure? ___________________________

Is your mouth dry? ___________________ Frequent mouth ulcers or canker sores? _______

Have you had any periodontal (gum) treatments? __________________________________

Have you had any problems associated with prior dental treatment? _______________________

____

How many times do you brush and floss your teeth? _____________________________________

Do you grind or brux your teeth? ____________________

How do you feel about your smile? ____

What is the reason for your dental visit today? ____

____

Medical History

Are you under the care of a physician? ___ yes ___no

Physician Name ____

Address ____

City ____ State ______________ Zip ___________

Please rate your overall health:

Excellent Good Fair Poor

Explain ____

Date of last exam? _________________________________ Are you pregnant? ___yes ___no

Are you taking or are you scheduled to begin taking osteoporosis medications Fosamax, Actonel, or Boniva? _________If so, how long have you been taking this medication?______________________

Have you been treated for osteoporosis, bone pain, hypercalcemia, or skeletal complications with intravenous (IV) bisphosphonates? (Aredia, Zometa) _______________________________________

Please list any medications:

Name ________________________________ Mg_____________ Reason _______________

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Name ________________________________ Mg_____________ Reason _______________

Name ________________________________ Mg_____________ Reason _______________

Please indicate if you have or have had any of the following diseases or problems:

__AIDS/HIV infection	__Heart Disease	__TMJ/Jaw Pain
__Anemia	__Heart Attack	__Other
__Arthritis	__Heart Murmur	________________________
__Artificial Joints	__Hepatitis	________________________
__Asthma	__High/Low Blood Pressure	________________________
__Anxiety	__Liver Disease	
__Autoimmune Disease	__Mental Disorder	
__Blood Disease	__Pacemaker	
__Cancer/Chemotherapy/Radiation	__Respiratory Problems	
__Chronic Pain	__Rheumatic Fever	
__Claustrophobia	__Rheumatism	
__Diabetes	__Sinus Problems	
__Dizziness/Fainting	__Sleep Disorder/Apnea	
__Epilepsy	__Stomach/Gastrointestinal problems	
__Excessive Bleeding	__Stroke	
__Fibromyalgia	__Thyroid	
__Head Injury	__Tuberculosis	

Allergies:

Please indicate if you have any of the following allergies:

Anesthetics ___

Aspirin ___

Penicillin or other antibiotics ___

Sedative or sleeping pills ___

Sulfa ___

Betadine ___

Codeine or other narcotics ___

Latex ___

Other _______________________________________

Daily Habits:

Do you use tobacco (cigarettes, chewing, or snuff)? ____yes ___no

If so, how many times per day? ____

Do you drink caffeinated drinks daily? ___yes ___no If so, how many per day ____________

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

The undersigned hereby authorizes any x-rays, models, photographs take, could be used for education, diagnosis, and lecturing purposes.

I authorize the following person (s) to receive information regarding my treatment:

____

Signature of Patient/Legal Guardian: _____________________________________Date_________