PATIENT HEALTH HISTORY

PATIENT INFORMATION

FIRST NAME	LAST NAME	PREFERRED NAME	
BIRTH DATE	AGE	SOCIAL SECURITY NO.	E-MAIL
STREET ADDRESS	CITY	ZIP	BILLING ADDRESS (IF DIFFERENT)
HOME PHONE	WORK PHONE	CELL PHONE	
EMPLOYER	OCCUPATION	REFERRED BY	DENTAL INSURANCE Yes ☐ No ☐

DENTAL INFORMATION

Do you notice any of the following:

	Yes	No		Yes	No		Yes	No
Teeth tender to chew on?	☐	☐	Sensitivity to sweets, hot or cold?	☐	☐	Swelling or lumps in mouth?	☐	☐
Bleeding or sore gums?	☐	☐	Clenching or grinding teeth?	☐	☐	Loose teeth?	☐	☐
Food caught between teeth?	☐	☐	Jaw clicking or popping?	☐	☐	Pain in jaw or face?	☐	☐
Dry Mouth?	☐	☐	Sensitivity to metals?	☐	☐	Wear dentures or partial?	☐	☐

Purpose of this dental visit?______________________________

Date of last dental visit____________ What was done?____________ Name of Dentist____________

Have you had problems with previous dental treatment?____________________

Do you have a high level of fear or require sedation for dental treatment?____________

Are you allergic to latex? Yes ☐ No ☐ Allergic to Penicillin? Yes ☐ No ☐

Allergic to other medications? Yes ☐ No ☐ ____________________

Have you used Bisphosponate drugs (for osteoporosis or for bone cancer)? Yes ☐ No ☐

Do you smoke or use tobacco? Yes ☐ No ☐ How Much?____________________

How often do you brush?____________________ Floss?____________________

INTEREST IN TOOTH WHITENING OR SMILE IMPROVEMENT

Are you interested in whitening your teeth? Yes ☐ No ☐ Are you interested in straightening your teeth? Yes ☐ No ☐

Are you happy with the appearance of your teeth? Yes ☐ No ☐ If not, what would you change?____________

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HEALTH HISTORY

PHYSICIAN'S NAME PHONE

IF YOU ARE BEING TREATED FOR A SERIOUS ILLNESS, PLEASE EXPLAIN

PLEASE LIST ANY MEDICATIONS YOU ARE TAKING

Have you had or do you currently have:

	Yes	No		Yes	No		Yes	No
Heart Disease	☐	☐	Diabetes	☐	☐	Hepatitus	☐	☐
Stroke	☐	☐	Excessive Bleeding	☐	☐	H.I.V. Positive	☐	☐
Artificial Heart Valve	☐	☐	Epilepsy or Seizures	☐	☐	Radiation Treatment	☐	☐
Artificial Joint (hip, knee, etc.)	☐	☐	Asthma	☐	☐	Mental Health Problem	☐	☐
Heart Pacemaker	☐	☐	Thyroid Problems	☐	☐	Frequent Headaches	☐	☐
High Blood Pressure	☐	☐	Glaucoma	☐	☐	Tuberculosis	☐	☐
Cancer	☐	☐	Herpes	☐	☐	Sinus Problems	☐	☐
Anemia	☐	☐	Eating disorder	☐	☐	Arthritis	☐	☐
Other Health Problems	☐	☐						

FOR WOMEN

Is it possible you may be pregnant? Yes ☐ No ☐ Are you nursing? Yes ☐ No ☐ Are you taking birth control pills? Yes ☐ No ☐

I understand the above information is necessary to provide safe treatment. I have answered all questions truthfully and to the best of my knowledge.

Signature ______________________________ Date ________________

(Parent's signature if patient is a minor)

UPDATES