

**NOELRIDGE DENTAL
HEALTH HISTORY**

Patient Name _____
Patient Date of Birth _____

Dental History

Please state the reason for today's visit: _____

Date of last visit to a dentist _____ Reason for last dental visit _____

Date of last dental cleaning _____ Date of last Full Mouth X-rays _____

How often do you have dental visits/examinations? _____

How often do you brush? _____ How often do you floss? _____

Do you use other dental aids (toothpicks, Sonicare, Waterpik, etc)? _____

Are you happy with the appearance of your teeth and smile? Yes No If no, what would make you feel better about it? _____

Do you have any dental problems at this time? Yes No If yes, please describe: _____

Previous Dental Office/Dentist: _____

Address: _____ Phone: _____

Please indicate "Yes" or "No" to the following:

Have you had any:

- Sensitive teeth? Yes No
- If yes, to hot or cold? Yes No
- Sweets? Yes No
- Biting or chewing? Yes No
- Mouth odors or bad tastes? Yes No
- Abscesses? Yes No
- Cold sores, canker sores, oral lesions? Yes No
- Bleeding or tender gums? Yes No
- Tooth loss due to gum disease/bone loss? Yes No
- Food traps between your teeth? Yes No
- Orthodontic treatment (braces)? Yes No
- Oral Surgery? Yes No
- Periodontal treatment? Yes No
- Bite adjustments or ground teeth? Yes No
- Clicking or popping of the jaw or jaw pain? Yes No

Do you:

- Grind or clench your teeth? Yes No
- Bite your nails or other objects? Yes No
- Smoke a pipe? Yes No
- Mouth breathe? Yes No
- Snore or experience sleep apnea ? Yes No
- Gag easily? Yes No
- Feel nervous about having dental treatment? Yes No

If yes, what is your greatest concern?

Please describe any "Yes" answers:

Is there any information about your dental treatment that you would like our office to know? Yes No If yes, please describe:

Medical History

Are you currently under the care of a physician? Yes No If yes, for what? _____

Physician's name: _____ City: _____ Phone: _____

Have you been a patient in a hospital in the past 5 years? Yes No If yes, for what? _____

Please list current prescription medications, over-the-counter medications, vitamins, herbals, and/or supplements:

Substance:	Dose/Frequency:	Reason for taking:	Substance:	Dose/Frequency:	Reason for taking:
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Pharmacy: _____ Phone: _____

Have you taken any oral cortisone, prednisone, or steroid in the past 2 years? Yes No If yes, dose and duration: _____

Have you had bisphosphonate therapy (Aredia, Zomata, Boniva, etc)? Yes No If yes, name and duration: _____

Have you had any allergic reactions (rash, hives, anaphylaxis) or adverse reactions (nausea, upset stomach, dizziness) to any medications or substances? Yes No If yes, please describe substance and reaction: _____

Have you ever been told to take antibiotic pre-medication before dental treatment? Yes No For what? _____

Do you currently or have you in the past used tobacco in any form? Yes No If yes, type, amount, and years: _____

Women: Are you pregnant? Yes No Weeks: _____ Are you nursing? Yes No
Are you taking birth control pills? Yes No

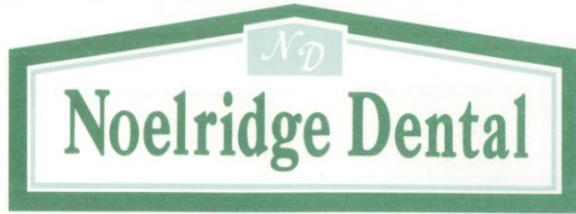
Please indicate "Yes" or "No" to any conditions you have had in the past or currently have:

Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neurological disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia or bulimia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, rheumatoid	<input type="checkbox"/> Yes <input type="checkbox"/> No	Food allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial joints (knee, hip)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fen-Phen or Redux use	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial heart valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rapid weight loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart murmurs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistant	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV positive or AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough up blood	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of hands or feet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drastic weight loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drug/alcohol dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Latex allergy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral valve prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers/colitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervousness/anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal disease/STD	<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you have any disease, problem, or condition not listed? Yes No If yes, please describe:

I have answered this health history to the best of my knowledge.

Signature (parent if minor) _____ Date _____



Patient Information

Date _____

Patient's name (last, first, middle) _____ Preferred name _____

Date of Birth _____ Social Security # _____ Gender _____ Marital Status _____

Home address _____

Mailing address (if different from residence) _____

Phone (home) _____ (work) _____ (cell/other) _____ How may we best reach you? _____

Employer _____ Occupation _____ # of years employed _____

Spouse/Domestic Partner's Information

Name (last, first, middle) _____ Preferred name _____

Date of Birth _____ Social Security # _____ Gender _____

Employer _____ Occupation _____ # of years employed _____

Dependants/Children

Name(s)	Date of birth	Gender	Grade	SS#	School
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Emergency Contact Information

Nearest contact/relative not living with you _____ Relationship to patient _____

Address _____ Phone _____

Referral

How did you learn about our office? _____

Is another member of your family or relative a patient at our office? _____

If yes, name and relationship? _____

Account Information/Responsible Party/Insurance Benefit Information

Insured's name (last, first, middle) _____ Relationship to patient _____

Insured's Residence Address (if different from above) _____

Insured's Mailing address (if different from residence) _____

Insured's Phone (home) _____ (work) _____ (cell/other) _____

Insured's Date of Birth _____ Insured's Soc. Security # _____

Insured's Employer _____ Insured's Occupation _____ # of years employed _____

Insurance Co _____ Group # _____ Local/Policy/ID # _____

Secondary Insurance Benefit/ Secondary Financially Responsible party

Insured's name (last, first, middle) _____ Relationship to patient _____

Insured's Residence Address (if different from above) _____

Insured's Mailing address (if different from residence) _____

Insured's Phone (home) _____ (work) _____ (cell/other) _____

Insured's Date of Birth _____ Insured's Soc. Security # _____

Insured's Employer _____ Insured's Occupation _____ # of years employed _____

Insurance Co _____ Group # _____ Local/Policy/ID # _____

Consent for Treatment

I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives, and other medication necessary. I fully understand using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I given consent to the doctor's or designated staff's use and disclosure of any oral, written, or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment, and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

I agree to be responsible for payment of all services rendered on my behalf or my dependants. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1½% late charge (18%APR) may be added to my account. If required, I also understand a check of my credit may be made.

Signature (specify if parent/guardian if minor) _____ Date _____

Witness _____