

INFORMATION AND HEALTH HISTORY

DATE _____

Patient's Name: _____

Birthday _____ / _____ / _____ Age _____ SS# _____

Residence Address _____

Street City State Zip

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Whom may we thank for referring you ? _____

Name of Spouse _____ A Patient to our office ? Yes No

EMPLOYER

Company's Name _____ Business Phone _____

Address _____

Street City State Zip

Occupation _____

INSURANCE

Prime Coverage

Secondary coverage

Employee Name _____

Employee Name _____

Insurance Co. _____

Insurance Co. _____

Group No. _____

Group No. _____

Employee SS# _____

Employee SS# _____

Birthday _____

Birthday _____

Company Name _____

Company Name _____

CHILD PATIENT INFORMATION

Parent must fill out information above

Father's Name _____ Mother's Name _____

Childs Name _____

Address _____

Street City State Zip

Birthday _____ / _____ / _____ Age _____ Female _____ Male _____

School _____ Grade _____

PARENTS ARE RESPONSIBLE FOR ALL CHARGES

Consent for Treatment, Authorization and release:

I certify that I have understood the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I am obliged to pay said office in accordance with its credit terms and policy. There will be a charges for any account turned over to collections and monthly finance charges. **Your appointment is time reserved for you. 48 Hrs. notice is required on all changes, otherwise a fee will be charged.**

Patient's Signature _____ Date _____

CONFIDENTIAL HEALTH HISTORY

Patient Name: _____

Date of Birth: _____

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes No Is your general health good?
If NO, explain _____
2. Yes No Has there been a change in your health within the last year?
If YES, explain _____
3. Yes No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
If YES, explain _____
4. Yes No Are you being treated by a physician now? If YES, explain _____
Date of last medical exam? _____ Reason for exam _____
5. Yes No Have you had problems with prior dental treatment?
If YES, explain _____
Date of last dental exam _____ Name of last treating dentist _____
6. Yes No Are you in pain now?
If YES, explain _____

II. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (Please Circle)

| | | |
|--------------------------------|--------------------------|-------------------------|
| Chest pain (angina) | Blood in stools | Frequent vomiting |
| Fainting spells | Diarrhea or constipation | Jaundice |
| Recent significant weight loss | Frequent urination | Dry mouth |
| Fever | Difficulty urinating | Excessive thirst |
| Night sweats | Ringing in ears | Difficulty swallowing |
| Persistent cough | Headaches | Swollen ankles |
| Coughing up blood | Dizziness | Joint pain or stiffness |
| Bleeding problems | Blurred vision | Shortness of breath |
| Blood in urine | Bruise easily | Sinus problems |

III. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please Circle)

| | | |
|---------------------------------|---------------------------------|----------------------------|
| Heart disease | AIDS/HIV | Psychiatric care |
| Family history of heart disease | Surgeries | Osteoporosis |
| Heart attack | Hospitalization | Thyroid disease |
| Artificial joint | Diabetes | Asthma |
| Stomach problems or ulcers | Family history of diabetes | Hepatitis |
| Heart defects | Tumors or cancer | Sexual transmitted disease |
| Heart murmurs | Chemotherapy | Herpes |
| Rheumatic fever | Radiation | Canker or cold sores |
| Skin disease | Arthritis, rheumatism | Anemia |
| Hardening of arteries | Emphysema or other lung disease | Liver disease |
| High blood pressure | Kidney or bladder disease | Eye disease |
| Seizures | Stroke | Transplants |
| Cosmetic surgery | Eating disorders | Tuberculosis |

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please Circle)

| | | |
|---|--------------|--------------|
| Aspirin | Valium | Tetracycline |
| Darvon | Demerol | Vicodin |
| Codeine | Penicillin | Percodan |
| Local anesthetic (Novacaine or Xylocaine) | Latex | Food |
| Nitrous oxide | Erythromycin | Metal |
| Others: _____ | | |

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS? (Please Circle)

| | | |
|----------------------------|--------------------------|-------------|
| Recreational drugs | Tobacco in any form | Antibiotics |
| Over-the-counter medicines | Alcohol | Supplements |
| Weight loss medications | Bisphosphonate (Fosamax) | Aspirin |
| Please list: <u>all</u> | | |

VI. WOMEN ONLY

- Yes No Are you or could you be pregnant?
If YES, what month? _____
- Yes No Are you nursing?
- Yes No Are you taking birth control pills?

VII. ALL PATIENTS

- Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain: _____
- Yes No Have you ever been pre-medicated for dental treatment? If YES, why _____
- Yes No Have you ever taken Fen-phen? If YES, when _____
- Yes No Is there any issue or condition that you would like to discuss with the dentist in private?

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature: _____

Date: _____

Physician's Name: _____

Phone Number: _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

| | | | |
|---|------|----------------------|------|
| Signature of Patient (Parent or Guardian) | Date | Signature of Dentist | Date |
|---|------|----------------------|------|

MEDICAL UPDATES

I have reviewed my Health History and confirm that it accurately states past and present conditions.

| DATE | PATIENT SIGNATURE | CHANGES TO HEALTH HISTORY | DENTIST INITIALS |
|-------|-------------------|---------------------------|------------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |