

HEALTH HISTORY

FOR YOUR WELFARE AND OUR EFFICIENCY OF DIAGNOSIS AND TREATMENT, PLEASE FILL IN THE FOLLOWING CONFIDENTIAL FORM COMPLETELY. PLEASE ANSWER ALL QUESTIONS.

Name _____ Name of Medical Physician _____

Birthdate _____ Sex: M _____ F _____

1. How is your general health?
EXCELLENT GOOD FAIR POOR
2. Do you have or have you had any of the following, please indicate with check marks ()

<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> AIDS or HIV+
<input type="checkbox"/> Any Heart Problems	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Radiation (x-ray) Treatments
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Hepatitis, Liver Disease	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Nervous Problems
<input type="checkbox"/> Low Blood Pressure	or Jaundice	<input type="checkbox"/> Anemia	<input type="checkbox"/> Psychiatric Problems
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Stroke	<input type="checkbox"/> Thyroid Condition	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Asthma or Hay Fever
<input type="checkbox"/> Mitral Valve Prolapse or Heart Murmur	<input type="checkbox"/> Allergies to Medicines or Drugs	<input type="checkbox"/> Mouth Ulcers	<input type="checkbox"/> Stomach Ulcer
		<input type="checkbox"/> Hormone Disorder	<input type="checkbox"/> Prosthetic (Artificial) Implants
3. Are you being treated by a physician now? _____
If yes, please give reason for treatment _____
4. Are you allergic to Penicillin, Codeine, aspirin or any other medications? _____
5. Are you subject to prolonged or excessive bleeding? _____
6. Do you take or have you taken any of the following: PLEASE CIRCLE: Marijuana, Methadone, Amphetamines, Tranquilizers, Heroin, Cocaine
7. Are you taking any other type of medication now? (If so, for what purpose?) _____

8. Have you had any serious illness or operation in the last 5 years? _____
9. Do you smoke? If yes, how much? _____
10. Have you ever been treated for Cancer or Tumor? If yes, describe type and treatment _____
11. (Female Only) Are you pregnant? _____
Are you on Birth Control Pills? _____
12. Have you ever required pre-medication (Antibiotics) for dental cleanings? _____
13. Approximate date of last dental visit _____
14. Approximate date when teeth were last cleaned _____
15. How often do you floss your teeth? _____
16. Do your gums ever bleed while brushing? _____
17. Does food catch between your teeth? _____
18. Do your gums ever feel tender or swollen? _____
19. Does hot, cold, or sweets cause pain in your mouth? _____
20. Do you clench your teeth during the day or night? _____
21. Have you ever had Periodontal Treatments or Gum Surgery? _____
22. Have you had any DIFFICULT extractions in the past? _____
23. Have you lost any teeth? _____
24. Have they ever been replaced by: PLEASE CIRCLE: Fixed Bridge, Removable Partial, or Denture
25. Are you familiar with the term "PREVENTITIVE DENTISTRY"? _____
26. Do you have any other disease, condition, or problem not listed above? _____

(NEXT)

PATIENT REGISTRATION (Must be completed)

PATIENT

NAME _____ DATE OF BIRTH _____
LAST FIRST INITIAL MO. DAY YEAR

ADDRESS _____
STREET / BOX NO
CITY STATE / ZIP PHONE (_____) _____

PARENTS NAME (IF CHILD) _____
LAST FIRST INITIAL

SOCIAL SECURITY NUMBER _____ MARITAL STATUS _____

EMPLOYER(S)

PATIENT EMPLOYED BY _____ HOW LONG _____

ADDRESS _____
STREET / BOX NO
CITY STATE / ZIP PHONE (_____) _____

SPOUSE EMPLOYED BY _____ HOW LONG _____

ADDRESS _____
STREET / BOX NO
CITY STATE / ZIP PHONE (_____) _____

EMERGENCY CONTACT

NAME _____ PHONE (_____) _____

ADDRESS _____
STREET / BOX NO CITY STATE

REFERRED BY

NAME _____ PHONE (_____) _____

ADDRESS _____
STREET / BOX NO CITY STATE

MEDICAL PHYSICIAN

NAME _____ PHONE (_____) _____

FORMER DENTIST

NAME _____ PHONE (_____) _____

DUE TO INCREASED COST OF MAILING STATEMENTS AND IN TRYING TO KEEP OUR FEES AS LOW AS POSSIBLE, WE FIND IT NECESSARY TO EXPECT OUR PATIENTS TO PAY FOR SERVICES AT THE TIME THEY ARE RENDERED, UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE BY OUR RECEPTIONIST/BUSINESS ASSISTANT. UNTIL ARRANGEMENTS ARE MADE WE WILL EXPECT PAYMENT EACH TIME WE SEE YOU. WE WANT TO GIVE YOU THE BEST AND MOST REASONABLE SERVICE POSSIBLE WITHOUT HAVING TO RAISE OUR FEES AND WILL APPRECIATE YOUR COOPERATION IN THIS MATTER.

I FULLY UNDERSTAND AND AGREE TO THE ABOVE POLICY

NAME _____ PHONE (_____) _____
PATIENT PLEASE SIGN

- Adult Patient Father (or Husband) Mother (or Wife) Legal Guardian