Health History Form

Thank you for visiting our office. We want your visit to be pleasant and comfortable. Please help us by completing this form.

All of this information is completely confidential.

Patient Information

Full Name (Last, First, Initial):	,
Preferred Name:	
Address:	
City State, Zip:	,
Phones:	**Home-** **Work-** **Cell-**
E-mail Address:	
Soc Sec #:	
Sex:	Male Female
Date of Birth:	
Marital Status:	Single Married Widowed Separated Divorced
Patient Employer/Occupation:	
Emergency Contact:	
Spouse's Name:	
Spouse's Employer/Occupation:	
How did you hear about our office?	

Responsible Party Information

Person Financially Responsible:	
Relation to patient:	
Address:	
City State, Zip:	,
Phones:	**Home-** **Work-**
Employer:	
Soc Sec #:	
Date of Birth:	

Dental Insurance Information

Is patient covered by dental insurance? ◉ Yes ○ No

(If yes, please complete the following:)

Policy Holder Name:

Relation to Patient:

Address:

City State, Zip: ,

Phones: **Home-** **Work-**

Soc Sec #:

Date of Birth:

Insurance Company Name:

Insurance Company Phone:

Group #:

Subscriber ID#:

Is patient covered by additional dental insurance? ◉ Yes ○ No

(If yes, please complete the following:)

Policy Holder Name:

Relation to Patient:

Address:

City State, Zip: ,

Phones: **Home-** **Work-**

Employer:

Soc Sec #:

Date of Birth:

Insurance Company Name:

Insurance Company Phone:

Group #:

Subscriber ID#:

INSURANCE AUTHORIZATION & FINANCIAL RESPONSIBILITY AGREEMENT

I understand that I am financially responsible for all charges whether or not paid by insurance. I assign all insurance benefits directly to the doctor otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature (Parent/Guardian if under age 18) | Relationship (if patient is under age 18) | Date

Medical History

Patient Name:

Physician's Name:

Phone:

Date of Last Visit:

Please check the box if you have ever had any of the following:

- AIDS or HIV positive
- Acid Reflux/ G.E.R.D
- Arthritis, (supply type below)
- Artificial joints
- Asthma
- Cancer
- Chemical Dependency
- Diabetes, (supply type below)
- Eating disorder
- Epilepsy
- Excessive bleeding
- Glaucoma
- Hepatitis, (supply type below)
- Kidney problems
- Liver problems or Jaundice
- Lung or breathing problems
- Sinus trouble
- Smoking/chewing tobacco
- Stroke
- Swollen neck glands
- Thyroid problems
- Tuberculosis

Heart Problems:

- Artificial valves
- Congential heart defects
- Heart Surgeries
- High blood pressure
- Infective (Bacterial) Endocarditis
- Low blood pressure
- Pacemaker
- Other (Supply details below)

Allergies:

- Aspirin
- Codeine
- Latex
- Local anesthetic
- Metals
- Penicillin
- Sulfa

Other Allergies:

Women:

Are you pregnant?

- No
- Yes

Due when?

Are you nursing?

- No
- Yes

- Antibiotics for dental treatment
- Currently under a physician's care
- Serious illnesses/hospitalizations

Medications: Please list medications you are currently taking and why

Dental History (New Patients Only)

Checkmark if you have ever had any of the following:

- Bad breath problem
- Biteguard / Nightguard
- Canker sores in mouth
- Cold sores on outer lips
- Dental anesthetic problems
- Excessive gag reflex
- Fear of dental care
- Frequent headaches, neck aches
- Full dentures / Partial dentures
- Oral surgery
- Orthodontics (braces)
- TMJ, jaw joint pain or treatment
- Gum disease treatment

Checkmark if you currently have any of the following:

- Bleeding gums
- Broken tooth or filling
- Clenching or grinding of teeth
- Clicking or popping jaw
- Dry mouth
- Food packing between teeth
- Loose tooth
- Mouth breathing
- Pain
- Sensitivity to - heat - cold - biting
- Sensitivity to - sweets - pressure
- Sores or growths in mouth

	☐ Swelling	☐ Tired, sore or painful jaw joint	☐ Toothache
	☐ Vague ache	☐ Pain around ear	
Other:			
Give details and location of the above checked items:			
How often do you brush?			
How often do you floss?			
What type toothbrush do you use?	◉ Ultrsoft ○ Soft ○ Medium ○ Hard ○ Electric		
Reason for today's visit			
Former Dentist	, **City/State:** **Phone:**		
Date and reason of last dental visit:			
Date of last dental X-rays:			
What have you liked about any dental office you've been to?			
What have you liked LEAST about any dental office you've been to?			

TREATMENT AUTHORIZATION

I have reviewed the information on this form and it is accurate to the best of my knowledge. I authorize and give consent for the dentist and/or team of this office to perform dental services as agreed between doctor and patient and/or guardian, including the use of local anesthetic and other medication as indicated.

Signature (Parent/Guardian if under age 18)	Relationship (if patient is under age 18)	Date

Please enter code above in the field below.

Submit