

Health History

Although dentists primarily treat the area in and around your mouth, it is important for us to know all the facts relative to your present and past health. Certain medications and health conditions could have an important interrelationship with the treatment that you will be receiving. The following information is strictly confidential.

Patient's Name: _____

1. Date of last Physical Exam: _____ Physician's Name: _____
2. Have you been hospitalized during the past two years? Yes/ No
Reason: _____
3. Have you been under the care of a physician in the past two years? Yes/No
Reason: _____
4. Are you allergic to (i.e.; itching, rash, swelling of hands, feet, or eyes) or made sick by penicillin, aspirin, codeine, local anesthetics, latex, metals, or any other medication? Yes/No
What? _____
5. Have you ever had excessive bleeding requiring special treatment? Yes/No
6. CIRCLE any of the following that you have had or have at present:

Glaucoma	Kidney Disorders	HIV Positive, ARC, AID
Heart Disease	Ulcers	Alcoholism
Chest Pain	Use of Tobacco Products	Drug Addiction
High Blood Pressure	Emphysema	Venereal Disease
* Mitral Valve Prolapse	Tuberculosis (TB)	Cortisone Medicine
* Heart Murmur	Fainting or Dizzy Spells	Nervousness
* Congenital Heart Lesions	Allergies or Hives	Hepatitis (Type: _____)
* Rheumatic Fever	Sinus Problems	Liver Disease
* Artificial Hip, Knee, Other Joint	Mental Disorders	Jaundice
* Redux or Pondimin (Fen Phen)	Thyroid Disease	Bruise Easily
* Dialysis	Arthritis	Blood Transfusion
Stroke	Epilepsy or Seizures	Anemia
Heart Surgery/ Pace Maker	Diabetes	Sickle Cell Disease
Cancer (Type: _____)	Cold Sores	Herpes
Chemotherapy	Radiation Treatment	High Cholesterol

*** Antibiotic premedication may be required prior to appointment to prevent serious recurrent infections**

8. WOMEN: Are you pregnant? Yes/No
Are you nursing? Yes/No
Are you taking birth control pills? Yes/No
(Antibiotics may reduce the effectiveness of birth control pills.)
9. Please list ALL medications you are currently taking (including over the counter medications, vitamins, or herbal remedies):

To the best of my knowledge, all of the information on both sides of this form is true and correct. If there is any change in my health, or my medications, I will inform the doctor prior to any treatment.

Signature

Date

I have reviewed my medical history and the above (including changes) is accurate:

Date: _____ Initials: _____ Date: _____ Initials: _____ Date: _____ Initials: _____
Date: _____ Initials: _____ Date: _____ Initials: _____ Date: _____ Initials: _____

Patient Information

PATIENT

Last Name: _____ First Name: _____ Middle Initial: _____
Address: _____ Date of Birth: _____
City: _____ State: _____ Zip: _____ Sex: _____
Employer: _____ Marital Status: _____ Soc Sec No. _____
Phone: Home: _____ Work: _____ Cell Phone: _____
Spouse's Name: _____ Employer: _____
If Minor: Mother's Name _____ Father's Name _____
Employer _____ Employer _____
Work Phone _____ Work Phone _____
Billing Address (If different then above): _____
Whom may we thank for referring you? _____

INSURANCE

Primary Dental Insurance Subscriber's Name: _____
Subscriber's Address: _____
City: _____ State: _____ Zip: _____
Subscriber's Soc. Sec. No. _____ Date of Birth: _____
Employer: _____ Relationship to Patient _____
Name of Insurance Co: _____ Group No: _____
Insurance Mailing Address: _____
City: _____ State: _____ Zip: _____

Secondary Dental Insurance Subscriber's Name: _____
Subscriber's Address: _____
City: _____ State: _____ Zip: _____
Subscriber's Soc. Sec. No. _____ Date of Birth: _____
Employer: _____ Relationship to Patient _____
Name of Insurance Co: _____ Group No: _____
Insurance Mailing Address: _____
City: _____ State: _____ Zip: _____

Due to the increasing complexity of all dental insurance programs it has become necessary for our office to place the responsibility of understanding the limitations and benefits of your Dental Insurance Policy on you, the patient or patient guardian. Thank you for helping us with this part of your care. At times the insurance requirements can become very convoluted and complex. You will be responsible for any co-payments, deductibles or the amounts the insurance carrier denies. The patient portion or co-payment is due at the time of service.

**If you are unable to keep your appointment
we request 24 hours advanced notice.**

APPOINTMENT FAILURE POLICY: After two missed appointments we will no longer be able to see you as a patient. We will attend to your emergency needs for the next 30 days. Upon written authorization we will be glad to forward your treatment records.