HEALTH HISTORY
(PLEASE PRINT)

Patient Name _____ **Driver's License #** _____ **S.S.#** _____/_____/_____

Spouses Name _____ **Driver's License #** _____ **S.S.#** _____/ _____/ _____

Address _____ **City** _____ **Zip** _____

Home Phone _____ **Cell Phone** _____

Birthdate ____/____/____ **Former Patient? Yes / No Male/Female Are you: Single / Married / Divorced / Widowed**

Employer/School _____ **Occupation** _____

Business Address _____ **Telephone (___)**_____

Spouse's Employer _____ **Telephone (___)**_____

Physician's Name _____ **Telephone (____)**_____

Are you presently being treated by a Physician? Yes / No Reason _____

Who may we thank for referring you? _____

LIST ALL MEDICINES, PILLS OR DRUGS YOU ARE NOW TAKING (prescription and over the counter):

Name of Drug	How often taken each day	Purpose of drug or disease being treated
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

DO YOU CURRENTLY HAVE:

Heart Murmur	**Yes / No**
Pacemaker	**Yes / No**
MVP (with or without regurgitation)	**Yes / No**
Knee or any Joint prosthesis	**Yes / No**

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

		WHEN			WHEN
Heart trouble	**Yes / No**	_____	**Ulcers**	**Yes / No**	_____
Jaundice	**Yes / No**	_____	**Tumor or Cancer**	**Yes / No**	_____
Congenital Heart Disease	**Yes / No**	_____	**Liver Disease**	**Yes / No**	_____
Rheumatic Heart Disease	**Yes / No**	_____	**Arthritis**	**Yes / No**	_____
Very high fever with disease	**Yes / No**	_____	**Diabetes**	**Yes / No**	_____
High / Low Blood Pressure	**Yes / No**	_____	**Glaucoma**	**Yes / No**	_____
Asthma, Hay fever, Allergies	**Yes / No**	_____	**Nervous Disorder**	**Yes / No**	_____
Pneumonia	**Yes / No**	_____	**Kidney Problems**	**Yes / No**	_____
Bronchitis	**Yes / No**	_____	**Urinating Problems**	**Yes / No**	_____
Tuberculosis or Lung Diseases	**Yes / No**	_____	**Excessive Urination**	**Yes / No**	_____
Constant Cough	**Yes / No**	_____	**Excessive Thirst**	**Yes / No**	_____
Emphysema	**Yes / No**	_____	**Anemia**	**Yes / No**	_____
Tobacco or Alcohol Habit	**Yes / No**	_____	**Hemophilia**	**Yes / No**	_____
Sinus Trouble	**Yes / No**	_____	**Other Blood Disorder**	**Yes / No**	_____
Epilepsy	**Yes / No**	_____	**Back Injury**	**Yes / No**	_____
High / Low Blood Sugar	**Yes / No**	_____	**Back Pain**	**Yes / No**	_____
Thyroid Problems	**Yes / No**	_____	**Stroke**	**Yes / No**	_____
Swelling of Ankles	**Yes / No**	_____	**HIV Positive**	**Yes / No**	_____
Shortness of Breath	**Yes / No**	_____	**AIDS**	**Yes / No**	_____
Faint Easily	**Yes / No**	_____	**Syphilis, Herpes**	**Yes / No**	_____
Steroid Therapy (Cortisone)	**Yes / No**	_____	**Gonorrhea**	**Yes / No**	_____
Hepatitis	**Yes / No**	_____			

HEALTH HISTORY

Hospitalization: _____

Are you allergic to Penicillin _____ Codeine _____ Local Anesthetics _____ Demerol _____ Valium _____Latex____
Any other medication allergies: _____
Are you pregnant? No _____ Yes _____ If yes, how many weeks/months? _____.

DENTAL HISTORY

How important is your smile to you on a scale of 1 to 10? _____ Ten being very important.

Do you fear dental visits? _____ If yes, please explain _____

Have you ever had any serious problems associated with dental visits? _____

Have you ever had excessive bleeding from minor wounds or extractions? _____

Have you ever been told you have periodontal problems? _____ Date _____

Date of last "yearly" dental x-rays _____ Have you ever had Nitrous Oxide? _____

Are you in pain today? _____ If yes, explain _____

INSURANCE INFORMATION

Primary Insurance Carrier _____ Group # _____ Employer _____

Name of Employee _____ Employees SS# _____

Employees Date of Birth _____ Relationship of patient to employee: self / spouse / child

Who is the person responsible for payment on this account? _____

If you are a college student and are carried by you parent's insurance, which college do you presently attend?

_____ Full Time _____ Part time _____

As a courtesy to our patients, we will gladly file your dental claims. We can only estimate the portion your insurance will pay, you are responsible for any portion NOT covered by your insurance company. It is your responsibility to understand the terms of your insurance policy. A Pre-Determination will be sent upon your request. It is your responsibility to find out if your policy has a waiting period.

******* Phone verification of insurance coverage is never a guarantee of payment. *******

PAYMENT IS REQUIRED WHEN SERVICES ARE RENDERED

Signature Date

Medical History and Patient Information Update:

Please update your health history as needed (at least once a year) then date and initial below:

Date: _____ change / no change initial _____ Date: _____ change / no change initial: _____

Date: _____ change / no change initial _____ Date: _____ change / no change initial: _____