HEALTH HISTORY

PATIENT INFORMATION

NAME: LAST _____ FIRST _____ MIDDLE _____ MARITAL STATUS_____

MAILING ADDRESS: Street _____City _____ State _____ ZIP _____

SOC. SEC.# _____ AGE _____ OCCUPATION: _____

EMPLOYER _____ BIRTH DATE _____ NO. OF YRS. EMPLOYED _____

Home Phone _____ Work Phone _____Cell _____

PARENT OR GUARDIAN

Name: Last _____ First _____ Middle _____

Address: _____

SOC. SEC.# _____ BIRTH DATE _____ Driver's License# _____

Relation to Patient _____ Employer _____

Occupation _____ No. of Yrs. Employed _____

DENTAL INSURANCE INFORMATION

PRIMARY CARRIER   SECONDARY CARRIER

Insured's Name _____ | Insured's Name _____
Insurance Co. _____ | Insurance Co. _____
Insurance Co. Address _____ | Insurance Co. Address _____
Insured's Employer _____ | Insured's Employer _____
Soc. Sec. # _____ Group # _____ Local #_____ | Soc. Sec.#_____ Group#_____ Local #_____
Birth Date _____ | Birth Date _____

AUTHORIZATION

I authorize and give consent to my dental provider to perform agreed upon procedures that may be necessary for proper dental care. These may include but are not limited to, diagnostic and therapeutic procedures, local anesthesia and the use of other medications as indicated. I confirm that the information on this page and the medical history are correct to the best of my knowledge. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of the dental treatment.
Payment for all treatment and services rendered are my responsibility.

PATIENT SIGNATURE _____ DATE _____

PARENT / GUARDIAN'S SIGNATURE_____ DATE _____

_____   _____
Patient's Name   Date of Birth   Height   Weight

Answer all questions by circling Yes (Y) or No (N)   All responses are kept confidential

1. Are you in good health?...Y   N
2. Has there been any change in your
   general health in the past year?................................Y   N
3. Date of last physical exam_____
4. Are you now under a physician's care for a particular
   problem?...Y   N
5. Have you ever had any serious illnesses, operations or
   hospitalizations? If so, describe:……………………..………..Y   N
   _____
   _____

6. DO YOU HAVE OR HAVE YOU EVER HAD:
   A. Rheumatic Fever of Rheumatic Heart Disease?.....................Y   N
   B. Congenital Heart Disease?............ ....Y   N
   C. Cardiovascular Disease (Heart Attack, Heart Trouble,
      Heart Murmur, Coronary Artery Disease, Angina,
      High Blood Pressure, Stroke, Palpitations, Heart Surgery
      Pacemaker)? …………………………………………...........Y   N
   D. Lung Disease (Asthma, Emphysema, COPD,
      Chronic Cough, Bronchitis, Pneumonia,
      Tuberculosis, Shortness of Breath, Chest Pain,
      Severe Coughing)?..Y   N
   E. Seizures, Convulsions, Epilepsy, Fainting or
      Dizziness?..Y   N
   F. Bleeding Disorder, Anemia, Bleeding Tendency,
      Blood Transfusion? Do you bruise easily?..............Y   N
   G. Liver Disease (Jaundice, Hepatitis)?......................Y   N
   H. Kidney Disease?............................. ....Y   N
   I. Diabetes?...Y   N
   J. Thyroid Disease (Goiter)?................. ....Y   N
   K. Arthritis?...Y   N
   L Stomach Ulcers or Colitis?........... ....Y   N
   M. Glaucoma?...Y   N
   N. Osteoporosis?..Y   N
   O. Implants placed anywhere in your body
      (Heart Valve, Pacemaker, Hip, Knee)?....................Y   N
   P. Radiation (X-ray) treatment for cancer?...................Y   N
   Q. Clicking or popping of jaw joint, pain near ear,
      difficulty opening mouth, grind or clench teeth?   Y   N
   R. Sinus or Nasal problems?........ ....Y   N
   S. Any disease, drug or transplant operation
      that has depressed your immune system?...............Y   N
7. ARE YOU USING ANY OF THE FOLLOWING:
   A. Antibiotics?..Y   N
   B. Anticoagulants (Blood Thinners)?............................Y   N
   C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? ………….Y   N
   D. High Blood Pressure medications?...........................Y   N
   E. Steroids (Cortisone, Prednisone, etc)……………………………Y   N
   F. Tranquilizers?..Y   N
   G. Insulin or Oral Anti-Diabetic drugs?........................Y   N
   H. Digital, Inderal, Nitroglycerin or other heart drugs?   Y   N

I. Are you taking or *have you ever taken* Bisphosphonates for
   osteoporosis, multiple myeloma or other cancers (Reclast,
   Fosamax, Actonel, Boniva, Aredia, Zometa)?...........................Y   N
J. Have you ever been advised not to take a Medication?..............Y   N
K. Please list any and all medications taken, including
   prescription medications, diet drugs, over-the-counter
   medications, herbal or holistic remedies, vitamins or minerals:
   _____
   _____

8. ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE
   REACTION TO:
   A. Local Anesthesia (Novacain, etc.)?..Y   N
   B. Penicillin or other antibiotics?..Y   N
   C. Sedatives, Barbiturates?...Y   N
   D. Aspirin or Ibuprofen?...Y   N
   E. Codeine or other pain killers?...Y   N
   F. Latex or Rubber products?...Y   N
   G. Metal of any kind?..Y   N
   H. Chemicals or jewelry (rash or sensitivity)?.................................Y   N
   I. Food products?..Y   N
   J. Other allergies or reactions? Please List   Y   N
   _____
   _____

9. Do you smoke or chew Tobacco?...Y   N
   How much per day?_____
10. Is there any past history of Alcohol or Chemical
    Dependency or Emotional Disorder that may affect the care
    we provide you?..Y   N
11. Have you had any serious problems associated with any
    previous dental treatment?...Y   N
12. Have you or an immediate family member had any problem
    associated with intravenous anesthesia? ....Y   N
13. Do you have any other disease, condition or problem not
    listed above that you think the doctor should know
    about?...Y   N
14. Do you wish to talk to the doctor privately about anything?
    …………………………………………………………………………..Y   N
15. Have you ever had a bone density scan?...................................Y   N
16. **FOR WOMEN ONLY**
    A. Are you Pregnant or is there any chance you might be
       Pregnant?..Y   N
B. Are you nursing?..Y   N
C. If you are using Oral Contraceptives, it is important that you
   understand that antibiotics (and some other medications)
   may interfere with the effectiveness of oral contraceptives.
   Therefore, you will need to use mechanical forms of birth control
   for one complete cycle of birth control pills, after the course of
   antibiotics or other medication is completed.
   Please consult with your physician for further guidance.

_____   _____
Patient/Parent/Guardian Signature   Date   Doctor's Signature   Date