

HEALTH HISTORY

Yes

No

Do You Have Allergy to Latex?

Have You Taken Fen-Phen Redux?

Are You Taking Any Medication?

Please List: _____

Name of Physician: _____

Phone Number of of Physician: _____

Sign: _____ **Date:** _____

RECALL REVIEW: _____

1. Patient's Signature _____ Date: _____

2. Patient's Signature _____ Date: _____

3. Patient's Signature _____ Date: _____

For Office Use Only

1. Doctor's Review _____ Date: _____

2. Doctor's Review _____ Date: _____

3. Doctor's Review _____ Date: _____

patient information

last name of patient	first name	middle	cell phone ()	home telephone ()	email
residence	city	State	ZIP	<input type="checkbox"/> single <input type="checkbox"/> married <input type="checkbox"/> divorced <input type="checkbox"/> widowed	sex <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
social security number	driver license no.	birthdate	age	occupation	
responsible party or spouse	relationship to patient	social security number	driver license no.		
address	city	ZIP	telephone ()		
employer	address	city	ZIP	work telephone ()	

insurance information

insured name	social security no.	birth date	relationship to patient
employer	address	city	ZIP
telephone	()		
dental insurance carrier	date employed	group number	
medical insurance carrier	date employed	group number	
are you covered by another plan?	yes _____ no _____	social security no.	birth date
group number			
if so, name of carrier:			

medical history of patient

YES NO

Do you have any general health problems?
If so, please specify: _____

Have you had surgery?
If so, please specify: _____

Are you currently under a physician's care?
Reason: _____

<input type="checkbox"/> <input type="checkbox"/> Any heart problems	YES NO	<input type="checkbox"/> <input type="checkbox"/> Malignancies
<input type="checkbox"/> <input type="checkbox"/> High blood pressure	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Measles
<input type="checkbox"/> <input type="checkbox"/> Low blood pressure	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Mumps
<input type="checkbox"/> <input type="checkbox"/> Circulatory problems	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Psychiatric care
<input type="checkbox"/> <input type="checkbox"/> Nervous problems	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> <input type="checkbox"/> Radiation treatments	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Scarlet fever
<input type="checkbox"/> <input type="checkbox"/> Excessive bleeding	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Sinus problems
<input type="checkbox"/> <input type="checkbox"/> AIDS (HIV)	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Stroke
<input type="checkbox"/> <input type="checkbox"/> Allergies to anesthetics	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Typhoid Fever
<input type="checkbox"/> <input type="checkbox"/> Allergies to medicines or drugs	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Tonsillitis
Allergies to: _____	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis
<input type="checkbox"/> <input type="checkbox"/> Anemia	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Ulcer
<input type="checkbox"/> <input type="checkbox"/> Arthritis	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Venereal Disease
<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Other
<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Are you pregnant?
<input type="checkbox"/> <input type="checkbox"/> Hepatitis	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Blood Pressure:
<input type="checkbox"/> <input type="checkbox"/> Herpes	<input type="checkbox"/> <input type="checkbox"/>	S ___ / ___ D ___ / ___

dental history of patient

What is your present dental problem? _____

When was your last visit to the dentist? _____

Why did you leave the Dental Office? _____

Are your teeth sensitive to
heat: _____ sweets: _____
cold: _____ biting pressure: _____

Does food catch between your teeth?	YES NO	<input type="checkbox"/> <input type="checkbox"/>
Do your gums bleed when brushing?	<input type="checkbox"/> <input type="checkbox"/>	
Have you noticed any gum swelling around any teeth?	<input type="checkbox"/> <input type="checkbox"/>	
Do you ever avoid any part of the mouth while brushing?	<input type="checkbox"/> <input type="checkbox"/>	
Are you satisfied with your teeth and their appearance?	<input type="checkbox"/> <input type="checkbox"/>	
Are you deeply concerned about the finances required to return your mouth to excellent dental health?	<input type="checkbox"/> <input type="checkbox"/>	
Do you get frustrated because you always have something to be treated or repaired when you visit a dentist?	<input type="checkbox"/> <input type="checkbox"/>	
Do you want to learn to control dental and gum disease?	<input type="checkbox"/> <input type="checkbox"/>	
Do you have bad breath or odor in your mouth?	<input type="checkbox"/> <input type="checkbox"/>	
Do you smoke?	<input type="checkbox"/> <input type="checkbox"/>	
Have you ever had any teeth removed?	<input type="checkbox"/> <input type="checkbox"/>	
How long have these teeth been missing? _____		
Have you had an allergic reaction to local anesthesia?	<input type="checkbox"/> <input type="checkbox"/>	

Who referred you to our office? _____

Person financially responsible (if other than patient) _____

How were your previous dental visits? _____

I, the undersigned shall be responsible for the payment of charges incurred for all services rendered.

I, the undersigned shall be responsible for the payment of all charges in excess of existing insurance coverage.

Permission is granted to perform necessary treatment for minor patient YES NO

Date: _____ Signature of Patient, Parent, or Guardian : _____