

Health History Form

ADA American Dental Association®

America's leading advocate for oral health

E-mail: _____ Today's Date: _____

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: Last First Middle	Home Phone: <i>Include area code</i> ()	Business/Cell Phone: <i>Include area code</i> ()
Address: Mailing address	City:	State: Zip:
Occupation:	Height:	Weight: Date of birth: Sex: M F
SS# or Patient ID:	Emergency Contact:	Relationship: Home Phone: Cell Phone: () () <i>Include area codes</i>

If you are completing this form for another person, what is your relationship to that person?

Your Name _____ Relationship _____

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the question)* Yes No DK

Active Tuberculosis.....

Persistent cough greater than a 3 week duration.....

Cough that produces blood.....

Been exposed to anyone with tuberculosis.....

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	No	DK		Yes	No	DK
Do your gums bleed when you brush or floss?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches or neck pains?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does food or floss catch between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you brux or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your mouth dry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have sores or ulcers in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any periodontal (gum) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures or partials?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had orthodontic (braces) treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you participate in active recreational activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any problems associated with previous dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your home water supply fluoridated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of your last dental exam: _____			
Do you drink bottled or filtered water?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What was done at that time? _____			
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY				Date of last dental x-rays: _____			
Are you currently experiencing dental pain or discomfort?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
What is the reason for your dental visit today? _____							
How do you feel about your smile? _____							

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK		Yes	No	DK
Are you now under the care of a physician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a serious illness, operation or been hospitalized in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physician Name: _____ Phone: <i>Include area code</i> ()				If yes, what was the illness or problem? _____			
Address/City/State/Zip: _____				Are you taking or have you recently taken any prescription or over the counter medicine(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you in good health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements: _____ _____ _____			
Has there been any change in your general health within the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
If yes, what condition is being treated? _____							
Date of last physical exam: _____							

Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)

Do you wear contact lenses?	Yes No DK	Do you use controlled substances (drugs)?.....	Yes No DK
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	Yes No DK	Do you use tobacco (smoking, snuff, chew, bidis)?	Yes No DK
Date: _____ If yes, have you had any complications?		If so, how interested are you in stopping?	
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	Yes No DK	(Circle one) VERY / SOMEWHAT / NOT INTERESTED	
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	Yes No DK	Do you drink alcoholic beverages?	Yes No DK
Date Treatment began: _____		If yes, how much alcohol did you drink in the last 24 hours?	
		If yes, how much do you typically drink in a week?	
Allergies - Are you allergic to or have you had a reaction to:	Yes No DK	WOMEN ONLY Are you:	
To all yes responses, specify type of reaction.		Pregnant?	Yes No DK
Local anesthetics	Yes No DK	Number of weeks:	
Aspirin	Yes No DK	Taking birth control pills or hormonal replacement?	Yes No DK
Penicillin or other antibiotics	Yes No DK	Nursing?	Yes No DK
Barbiturates, sedatives, or sleeping pills	Yes No DK	Metals	Yes No DK
Sulfa drugs	Yes No DK	Latex (rubber)	Yes No DK
Codeine or other narcotics	Yes No DK	Iodine	Yes No DK
		Hay fever/seasonal	Yes No DK
		Animals	Yes No DK
		Food	Yes No DK
		Other	Yes No DK

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

Artificial (prosthetic) heart valve	Yes No DK	Autoimmune disease	Yes No DK	Hepatitis, jaundice or liver disease	Yes No DK
Previous infective endocarditis	Yes No DK	Rheumatoid arthritis	Yes No DK	Epilepsy	Yes No DK
Damaged valves in transplanted heart	Yes No DK	Systemic lupus erythematosus	Yes No DK	Fainting spells or seizures	Yes No DK
Congenital heart disease (CHD)		Asthma	Yes No DK	Neurological disorders	Yes No DK
Unrepaired, cyanotic CHD	Yes No DK	Bronchitis	Yes No DK	If yes, specify:	
Repaired (completely) in last 6 months	Yes No DK	Emphysema	Yes No DK	Sleep disorder	Yes No DK
Repaired CHD with residual defects	Yes No DK	Sinus trouble	Yes No DK	Mental health disorders	Yes No DK
Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.		Tuberculosis	Yes No DK	Specify:	
		Cancer/Chemotherapy/ Radiation Treatment	Yes No DK	Recurrent Infections	Yes No DK
		Chest pain upon exertion	Yes No DK	Type of infection:	
Cardiovascular disease	Yes No DK	Chronic pain	Yes No DK	Kidney problems	Yes No DK
Angina	Yes No DK	Diabetes Type I or II	Yes No DK	Night sweats	Yes No DK
Arteriosclerosis	Yes No DK	Eating disorder	Yes No DK	Osteoporosis	Yes No DK
Congestive heart failure	Yes No DK	Malnutrition	Yes No DK	Persistent swollen glands in neck	Yes No DK
Damaged heart valves	Yes No DK	Gastrointestinal disease	Yes No DK	Severe headaches/ migraines	Yes No DK
Heart attack	Yes No DK	G.E. Reflux/persistent heartburn	Yes No DK	Severe or rapid weight loss	Yes No DK
Heart murmur	Yes No DK	Ulcers	Yes No DK	Sexually transmitted disease	Yes No DK
Low blood pressure	Yes No DK	Thyroid problems	Yes No DK	Excessive urination	Yes No DK
High blood pressure	Yes No DK	Stroke	Yes No DK		
Other congenital heart defects	Yes No DK	Glaucoma	Yes No DK		
Mitral valve prolapse	Yes No DK				
Pacemaker	Yes No DK				
Rheumatic fever	Yes No DK				
Rheumatic heart disease	Yes No DK				
Abnormal bleeding	Yes No DK				
Anemia	Yes No DK				
Blood transfusion	Yes No DK				
If yes, date:					
Hemophilia	Yes No DK				
AIDS or HIV infection	Yes No DK				
Arthritis	Yes No DK				

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

Name of physician or dentist making recommendation: _____ Phone: _____

Do you have any disease, condition, or problem not listed above that you think I should know about?

Please explain: _____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
 I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____

PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU START HERE

DATE				1
LAST NAME		FIRST	M.I.	
PREFERS TO BE CALLED BY				
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.		FAX		
CELL		EMAIL		
BIRTHDATE	AGE	MALE	FEMALE	
MARRIED	SINGLE	DIVORCED	WIDOWED	
SOCIAL SECURITY NO.				

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

DATE			
LAST NAME		FIRST	M.I.
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.			
BIRTHDATE	AGE	MALE	FEMALE
SCHOOL		GRADE	
SOCIAL SECURITY NO.			

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

DENTAL INSURANCE		2
PRIMARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYER NAME		
INSURED'S NAME		
DATE OF BIRTH	RELATIONSHIP TO PATIENT	
INSURED'S I.D. NO.		
INSURED'S SOCIAL SECURITY NO.		
SECONDARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYER NAME		
INSURED'S NAME		
DATE OF BIRTH	RELATIONSHIP TO PATIENT	
INSURED'S I.D. NO.		
INSURED'S SOCIAL SECURITY NO.		

ACCOUNT INFORMATION		4
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
NAME		
RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.	
ADDRESS		
CITY	STATE	ZIP
PHONE NO.		
YOU		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	
YOUR SPOUSE		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	

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GETTING TO KNOW YOU		3
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?		
NAME:	RELATIONSHIP:	
YOU WERE REFERRED TO US BY		
YOUR FORMER ADDRESS		
CITY	STATE	ZIP
PERSON TO CONTACT FOR EMERGENCY		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP

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CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature _____ Date _____ Witness _____

Parent/Responsible Party's Signature _____ Relationship to Patient _____