WELCOME TO OUR OFFICE

Today's Date _____

Name _____ Date of Birth _____
Last First M.I

Address _____ Home Phone _____

_____ Cell Phone _____

Email Address _____ Marital Status _____

Place of Employment _____ Office Phone _____

Full name of Spouse/Parent _____ Spouse's Occupation _____

How did you hear about our office? _____ Person Responsible for account _____

Dental Insurance Company _____ Social Security Number _____

Physician's Name _____ Date of Last Exam _____

In Case of Emergency _____ Phone _____

Preferred Method of Contact _____

CHECK YES OR NO

PATIENT MEDICAL HISTORY

☐ YES ☐ NO Are you under any Medical treatment now?
☐ YES ☐ NO Have you had any major operations?
If so, what? _____
☐ YES ☐ NO Have you ever had an accident involving head or jaw?
☐ YES ☐ NO Have you had any adverse response to any drugs, including penicillin and aspirin?
☐ YES ☐ NO Have you ever had any of the following?

☐ Heart Ailment	☐ Any Blood Disease
☐ Heart Murmur	☐ Any Blood Disorder
☐ High Blood Pressure	☐ Any Liver Disease
☐ Low Blood Pressure	☐ Any Kidney Disease
☐ Respiratory Disease	☐ Any Stomach Disease
☐ TB	☐ Any Venereal Disease
☐ Diabetes	☐ HIV/AIDS
☐ Rheumatic Fever	☐ Yellow Jaundice or Hepatitis
☐ Arthritis	☐ Epilepsy
☐ Tumors or Growths	☐ Nervous Disorder
☐ Cancer	☐ Osteoporosis

☐ Other (specify) _____

☐ YES ☐ NO Are you now taking drugs or medications?
☐ YES ☐ NO Are you allergic to any materials resulting in hives, asthma, eczema, etc.?
☐ YES ☐ NO Do you have any reason to suspect you are not in good health?
☐ YES ☐ NO Have any wounds healed slowly or had other complications?
☐ YES ☐ NO Are you pregnant?
☐ YES ☐ NO Do you have a history of fainting?
☐ YES ☐ NO Do you have sleep apnea?
☐ YES ☐ NO Have you ever had any radiation or chemotherapy?
☐ YES ☐ NO Have you ever received any artificial heart valves, vessels, or donor organs?
☐ YES ☐ NO Do you have a pacemaker?
☐ YES ☐ NO Do you have any artificial joints?
☐ YES ☐ NO Do you drink alcohol? How often?
☐ YES ☐ NO Do you use any illicit drugs?
☐ YES ☐ NO Do you use cigarettes, cigars, snuff, chewing tobacco? How much?
☐ YES ☐ NO Do you have any other problems not listed above?

CURRENT MEDICATION – REASON

COMMENTS

MEDICAL ALERT

CERTIFICATION: I certify that the answers given are correct to the best of my knowledge.

Signature _____ **Date** _____

WELCOME TO OUR OFFICE

PATIENT MEDICAL HISTORY

☐ YES ☐ NO Are you happy with the appearance of your teeth?
☐ YES ☐ NO Do you wish to keep your natural teeth?
☐ YES ☐ NO Have you ever had a bad dental experience?
☐ YES ☐ NO Have you had regular check-ups in the past?
How often? _____
☐ YES ☐ NO Have you ever had any reaction to Novocaine anesthetic?
☐ YES ☐ NO Have you ever been instructed in the care of your teeth and gums?
☐ YES ☐ NO Do you breathe through your mouth at night?
☐ YES ☐ NO Do you feel you have dry mouth or bad breath?
☐ YES ☐ NO Do you have any pain in or near your ears?
☐ YES ☐ NO Do you have any blisters, growths, or sore spots in or around your mouth?
☐ YES ☐ NO Does any part of your mouth hurt when clenched?
☐ YES ☐ NO Do you chew on only one side of your mouth?
☐ YES ☐ NO Do you habitually clench your teeth, day or night?
☐ YES ☐ NO Have you had any difficult extractions in the past or prolonged bleeding after extractions?
☐ YES ☐ NO Do your gums bleed?
☐ YES ☐ NO When was your last full mouth X-ray taken?
Where? _____
☐ YES ☐ NO Is any part of your mouth sore to pressure or irritants, such as cold, hot, sweets, etc.?
If so, locate: _____
☐ YES ☐ NO Any history of orthodontics - braces?
Do you still wear retainers? _____

IF PATIENT IS A CHILD, PLEASE ANSWER

☐ YES ☐ NO Any history of thumbsucking, pacifier use, mouth breathing, nail biting, or unusual speech patterns?
☐ YES ☐ NO Does child drink tap water? City water?
☐ YES ☐ NO Does child go to bed with a bottle?

IF PATIENT HERE FOR DENTURES, PLEASE ANSWER

☐ YES ☐ NO Have you had previous dentures?
If so, how many? _____
When was last set made? _____
when where teeth removed? _____
☐ YES ☐ NO Do you like the appearance of your present denture?
☐ YES ☐ NO Has your present denture ever been relined or rebased?

COMMENTS

TREATMENT AUTHORIZATION

I hereby grant authority to the dentist in charge of the patient whose name appears on this health history form, to administer any treatment and to administer such X-rays, anesthetics, sedatives, or nitrous oxide, and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

Signed _____ Date _____

Relationship to patient _____

MEDICAL HISTORY RECERTIFICATION

I certify that there have been no changes in my health except as noted below:

Date	Change	Signature