# *HEALTH HISTORY - UPDATES*

Have there been any changes in your health since your last dental appointment? ☐ Yes ☐ No
If Yes, for what conditions? ______________________________

______________________________

Are you taking any new medications? ☐ Yes ☐ No
If Yes, please list the medications. ______________________________

______________________________

______________________________

Patient's Signature ______________________ Date: ______________________
Reviewed by ______________________ Date: ______________________

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Have there been any changes in your health since your last dental appointment? ☐ Yes ☐ No
If Yes, for what conditions? ______________________________

______________________________

Are you taking any new medications? ☐ Yes ☐ No
If Yes, please list the medications. ______________________________

______________________________

______________________________

Patient's Signature ______________________ Date: ______________________
Reviewed by ______________________ Date: ______________________

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Have there been any changes in your health since your last dental appointment? ☐ Yes ☐ No
If Yes, for what conditions? ______________________________

______________________________

Are you taking any new medications? ☐ Yes ☐ No
If Yes, please list the medications. ______________________________

______________________________

______________________________

Patient's Signature ______________________ Date: ______________________
Reviewed by ______________________ Date: ______________________

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Have there been any changes in your health since your last dental appointment? ☐ Yes ☐ No
If Yes, for what conditions? ______________________________

______________________________

Are you taking any new medications? ☐ Yes ☐ No
If Yes, please list the medications. ______________________________

______________________________

______________________________

Patient's Signature ______________________ Date: ______________________
Reviewed by ______________________ Date: ______________________

**Patient Name:** ______________________________

Physician's Name ______________________________ Phone Number ________________ State_____

Place a mark in the box for "**Yes**" or "**No**" to indicate if you have or have had any of the following:

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| AIDS/HIV | ☐ | ☐ | Epilepsy | ☐ | ☐ | Pacemaker | ☐ | ☐ |
| Anemia | ☐ | ☐ | Fainting or Dizziness | ☐ | ☐ | Pregnant | ☐ | ☐ |
| Arthritis | ☐ | ☐ | Fluoride in your water? | ☐ | ☐ | Psychiatric Care | ☐ | ☐ |
| Artificial Joints | ☐ | ☐ | Glaucoma | ☐ | ☐ | Radiation Treatment | ☐ | ☐ |
| Asthma | ☐ | ☐ | Headaches | ☐ | ☐ | Respiratory Disease | ☐ | ☐ |
| Back or Neck Problems | ☐ | ☐ | Heart Conditions | ☐ | ☐ | Snoring | ☐ | ☐ |
| Bleeding/Clotting Abnormality | ☐ | ☐ | Heart Murmur | ☐ | ☐ | Stroke | ☐ | ☐ |
| Cancer:________________ | ☐ | ☐ | Hepatitis: Type ______ | ☐ | ☐ | Swelling of Feet/Ankles | ☐ | ☐ |
| Chemical Dependency | ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Swollen Neck Glands | ☐ | ☐ |
| Congenital Heart Lesions | ☐ | ☐ | Kidney Disease | ☐ | ☐ | Thyroid Problems | ☐ | ☐ |
| Cortisone/Steroid Treatments | ☐ | ☐ | Liver Disease | ☐ | ☐ | Tuberculosis | ☐ | ☐ |
| Diabetes-Type:__________ | ☐ | ☐ | Mitral Valve Prolapse | ☐ | ☐ | Weight Loss:unexplained | ☐ | ☐ |
| Tobacco: | ☐ | ☐ | Fosamax, Zometa | ☐ | ☐ | Aredia, Actonel | ☐ | ☐ |

Cigarettes per day ______________ For how long________ Drinks of alcohol a week? ______________

Chewing tobacco per day ____________ For how long________

Any other medical conditions not listed: ______________________________________________

**MEDICATIONS** ☐ NONE

1- ____________________ 2- ____________________

3- ____________________ 4- ____________________

5- ____________________ 6- ____________________

7- ____________________ 8- ____________________

9- ____________________ 10- ____________________

Pharmacy Name ______________________#__________

**ALLERGIES**

| | |
|---|---|
| ☐ Aspirin | ☐ Latex |
| ☐ Acrylic | ☐ Metal |
| ☐ Barbiturates | ☐ Penicillin |
| ☐ Codeine | ☐ Sulfa |
| ☐ Local Anesthetic | ☐ NONE |
| ☐ Other ______________________ | |

**DENTAL HISTORY**

Reason for today's visit:______________

________________________________

________________________________

Former Dentist ____________________

City/State ________________________

Date of last dental visit ______________

Date of last dental X-rays ____________

Mark "**Yes**" or "**No**" to indicate if you have/had any of the following:

| | Yes | No |
|---|---|---|
| Bad breath | ☐ | ☐ |
| Bleeding gums | ☐ | ☐ |
| Blisters on lips or mouth | ☐ | ☐ |

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Broken fillings | ☐ | ☐ | Mouth breathing | ☐ | ☐ |
| Burning sensation tongue | ☐ | ☐ | Mouth pain, brushing | ☐ | ☐ |
| Chew on side of mouth | ☐ | ☐ | Orthodontic treatment | ☐ | ☐ |
| Clicking or popping jaw | ☐ | ☐ | Pain around ear | ☐ | ☐ |
| Dry mouth | ☐ | ☐ | Periodontal treatment | ☐ | ☐ |
| Fingernail biting | ☐ | ☐ | Sensitivity to cold | ☐ | ☐ |
| Food between teeth | ☐ | ☐ | Sensitivity to heat | ☐ | ☐ |
| Grind teeth/clenching | ☐ | ☐ | Sensitivity to sweets | ☐ | ☐ |
| Gums swollen or tender | ☐ | ☐ | Sensitivity when biting | ☐ | ☐ |
| Jaw pain or tiredness | ☐ | ☐ | Sores/growths in mouth | ☐ | ☐ |
| Jaw surgery | ☐ | ☐ | Brush your tongue? | ☐ | ☐ |
| Lip or cheek biting | ☐ | ☐ | How often do you floss? ________ | | |
| Loose teeth | ☐ | ☐ | How often do you brush? ________ | | |

Is there anythig you would change about your smile? Please describe: ______________________

**Patients Signature:** ______________________________ **Date:** __________________

Reviewed by ____________ Date ________

# PATIENT INFORMATION

## PERSONAL INFORMATION

**Last Name**____________________ **First Name**________________ **MI** ______

**Mailing Address**____________________ **Apt #**____ **City**__________ **State**____ **Zip** ______

**Date of Birth**___/___/____ **SSN #** ____-____-____ **Marital Status**: M S D W **Sex**: M F

**Employer** ____________________ **Occupation** ____________________

| Patient Contact Information | OK to Leave Detailed Message? | |
|---|---|---|
| **Home:** ( ) - | ☐ Yes | ☐ No |
| **Work/Day:** ( ) - | ☐ Yes | ☐ No |
| **Cell:** ( ) - | ☐ Yes | ☐ No |
| **Text Appointment Reminders?** | ☐ Yes | ☐ No |
| **Email:** ________@________ | ☐ Yes | ☐ No |

**Billing Preferance:** ☐ **Email** ☐ **Mail** ☐ **Text**

Emergency Person We Can Contact (Other than your family home) ____________________

Who Can We Thank for Referring You to Our Office? ____________________

Names of other Family Members That Are Patients Here ____________________

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Parent Info **(if patient is a child)** Last Name __________ First Name __________ MI ____

DOB___/___/____ SS# ____-____-____

Spouse Information (if applicable) Last Name __________ First Name __________ MI ____

Spouse Employer __________ Occupation __________ Phone (___)________

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**None?** ☐

## DENTAL INSURANCE INFORMATION

**Have Card** ☐

**Relationship to Subscriber** ☐ **Self** ☐ **Spouse** ☐ **Dependant**

Subscriber's Name ____________________ Employer __________

Subscribers ID/ SS# ____-____-____ Subscribers Date of Birth ___/___/___

Insurance Company Name ________________ Group # ________________

**Secondary Coverage?** ☐ **Yes** ☐ **No**

Patient's Relationship to Subscriber ☐ **Self** ☐ **Spouse** ☐ **Dependant**

Subscriber's Name ____________________ Employer __________

Subscribers ID/ SS# ____-____-____ Subscribers Date of Birth ___/___/___

Insurance Company Name ________________ Group # ________________

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By my signature below I acknowledge receipt of the **Notice of Privacy Practices**. See provided documents

★ **Signature:** ________________ **Date:** ___/___/____ | Relationship to Patient: ____________