CONFIDENTIAL HEALTH HISTORY

Patient Name: _____ **Date of Birth:** _____

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes No Is your general health good?
   If NO, explain _____
2. Yes No Has there been a change in your health within the last year?
   If YES, explain _____
3. Yes No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain _____
4. Yes No Are you being treated by a physician now? If YES, explain _____
   Date of last medical exam? _____Reason for exam _____
5. Yes No Have you had problems with prior dental treatment?
   If YES, explain _____
   Date of last dental exam _____Name of last treating dentist _____
6. Yes No Are you in pain now? If YES, explain _____

II. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (Please Circle)

Chest pain (angina)	Blood in stools	Frequent vomiting
Fainting spells	Diarrhea or constipation	Jaundice
Recent significant weight loss	Frequent urination	Dry mouth
Fever	Difficulty urinating	Excessive thirst
Night sweats	Ringing in ears	Difficulty swallowing
Persistent cough	Headaches	Swollen ankles
Coughing up blood	Dizziness	Joint pain or stiffness
Bleeding problems	Blurred vision	Shortness of breath
Blood in urine	Bruise easily	Sinus problems

III. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please Circle)

Heart disease	AIDS/HIV	Psychiatric care
Family history of heart disease	Surgeries	Osteoporosis
Heart attack	Hospitalization	Thyroid disease
Artificial joint	Diabetes	Asthma
Stomach problems or ulcers	Family history of diabetes	Hepatitis (type: _____)
Heart defects	Tumors or cancer	Sexually transmitted disease
Heart murmurs	Chemotherapy	Herpes
Rheumatic fever	Radiation	Canker or cold sores
Skin disease	Arthritis/rheumatism	Anemia
Hardening of arteries	Emphysema or other lung disease	Liver disease
Pacemaker	Glaucoma	Blood transfusions
High blood pressure	Kidney or bladder disease	Eye disease
Seizures or Epilepsy	Stroke	Transplants
Cosmetic surgery	Eating disorders	Tuberculosis (PPD positive)

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please Circle)

Aspirin	Valium	Tetracycline
Darvon	Demerol	Vicodin
Codeine	Penicillin	Percodan
Local anesthetic	Latex	Food
Nitrous oxide	Erythromycin	Metal

Others: _____

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS? (Please Circle)

Recreational drugs	Tobacco in any form	Antibiotics
Over-the-counter medicines	Alcohol	Supplements
Weight loss medications	Bisphosphonate (Fosamax)	Aspirin

PLEASE LIST ALL MEDICATIONS INCLUDING SUPPLEMENTS: _____

_____

VI. ADDITIONAL MEDICAL HISTORY

Yes No Have you ever taken bisphosphonates? If YES, for how long _____

Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain: _____

_____

Yes No Have you ever been pre-medicated for dental treatment? If YES, why _____

Yes No Have you ever taken Fen-phen? If YES, when _____

Yes No Is there any issue or condition that you would like to discuss with the dentist in private?

VII. WOMEN ONLY

Yes No Are you or could you be pregnant? If YES, what month? _____

Yes No Are you nursing?

Yes No Are you taking birth control pills?

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient' Signature: _____ Date: _____

Physician's Name: _____ Phone Number: _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature of Patient (Parent or Guardian) Date Signature of Dentist Date

MEDICAL UPDATES

I have reviewed my Health History and confirm that it accurately states past and present conditions.

Date	Patient Signature	Changes to Health History	Dental Provider Initials
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Emergency Contact (name and telephone number): _____

PATIENT INFORMATION

Patient Name: _____
Last Name First Name Preferred Name

Title: Dr. Mr. Mrs. Ms. **Gender:** Male Female **Family Status:** Married Single Child Other

Date of Birth:_____ **Email Address:**_____

Home Phone:_____ **Work Phone (ext):** _____ **Mobile:** _____

Address: _____
Street City State Zip

Whom may we thank for referring you to our practice?

_____
Dental Office | Internet | Work | Yellow Pages | Other

SPOUSE or RESPONSIBLE PARTY INFORMATION

The following is for: □ the patient's spouse □ the person responsible for payment □ neither (not applicable)

Name: _____
Last Name First Name Preferred Name

Title: Dr. Mr. Mrs. Ms. **Gender:** Male Female **Family Status:** Married Single Child Other

Birth Date:_____ **Email Address:**_____

Home Phone:_____ **Work Phone (ext):** _____ **Mobile:** _____

Address: _____
Street City State Zip

EMPLOYMENT INFORMATION

The following is for: □ the patient's spouse □ the person responsible for payment □ neither (not applicable)

Employer Name: _____ **Phone:**_____

Address: _____
Street City State Zip

PRIMARY DENTAL INSURANCE INFORMATION

Name of Insured: _____
Last Name First Name

Insured's Birth Date: _____ **ID#** _____ **Group #:** _____

Insured's Address: _____
(If different than patient) Street City State Zip

Insured's Employer Name: _____

Employer Address: _____
Street City State Zip

Patient's relationship to insured: □ Self □ Spouse □ Child □ □ Other

Insurance Plan Name: _____

Insurance Address: _____
Street City State Zip

SECONDARY INSURANCE INFORMATION

Name of Insured: _____
Last Name First Name

Insured's Birth Date: _____ **ID#** _____ **Group #:** _____

Insured's Address: _____
(If different than patient) Street City State Zip

Insured's Employer Name: _____

Insured's Employer Address: _____
Street City State Zip

Patient's relationship to insured: □ Self □ Spouse □ Child □ □ Other

Insurance Plan Name: _____

Insurance Address: _____
Street City State Zip

CONSENT FOR SERVICES AND FINANCIAL ARRANGEMENTS

We are committed to providing you with the best possible care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy. Payment for service is due at the time service is rendered. For your convenience, payment can be made with cash, check, American Express, Discover Card, Master Card and Visa. Returned checks and balances older than 30 days will be subject to additional fees and interest charges of 1.5% per month. There may also be charges for broken appointments and appointments canceled without 24 hours advance notice.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services that they will not cover. We must emphasize that as dental care providers, our relationship is with you, not with your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment. I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent, or guardian (responsible party): _____ Date: _____