# Welcome

We would like to welcome you to our office. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible. Thank you for your cooperation.

## Patient Information

Name: _____ _____ _____ Sex:_____
Last First Middle

Address: _____ _____ _____ _____
Street City State Zip

Birthdate: _____ E-mail: _____ Social Security: _____
MM-DD-YYYY 999-99-9999

Home Phone: _____ Cell Phone: _____ Work Phone: _____ ext. _____
999-999-9999 999-999-9999 999-999-9999

Employer: _____ Occupation: _____ No. Years Employed _____

Whom may we thank for referring you to our office: _____

## Spouse/Additional Contact Information

Name: _____ _____ _____ _____
Last First Middle Marital Status

Address: _____ _____ _____ _____
Street City State Zip

Birthdate: _____ E-mail: _____ Relationship to Patient: _____
MM-DD-YYYY

Home Phone: _____ Cell Phone: _____ Work Phone: _____ ext. _____
999-999-9999 999-999-9999 999-999-9999

Employer: _____ Occupation: _____ No. Years Employed _____

## Insurance Information

<u>Primary Insurance</u>

Policy Owner's Name: _____ Policy Owner's Social Security #: _____
999-99-9999

Policy Owner's Birthdate: _____ Relationship to Patient: _____
MM-DD-YYYY

Policy Owner's Employer: _____ Employer Address: _____

Insurance Company: _____ Group No. (plan, local or policy) _____

Insurance Co. Address: _____ Insurance Phone No. _____

<u>Secondary Insurance</u>

Policy Owner's Name: _____ Policy Owner's Social Security #: _____
999-99-9999

Policy Owner's Birthdate: _____ Relationship to Patient: _____
MM-DD-YYYY

Policy Owner's Employer: _____ Employer Address: _____

Insurance Company: _____ Group No. (plan, local or policy) _____

Insurance Co. Address: _____ Insurance Phone No. _____

# Confidential Health History Form

Patient Name: First_____ MI _____ Last _____ Date of Birth: _____

I. Check the 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 3 years?

   If YES, explain_____

4. ☐ Yes ☐ No Are you being treated by a physician now? Physician: _____ Phone #: _____

   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_____

6. ☐ Yes ☐ No Are you in pain now?

   If YES, explain_____

***II.*** **Have you experienced any of the following? (*Please check Yes or No for each)***

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

***III.*** **Have you had or do you have any of the following? (*Please check Yes or No for each)***

| | | |
|---|---|---|
| ☐ Y ☐ N Heart disease | ☐ Y ☐ N Cosmetic surgery | ☐ Y ☐ N Eating disorder |
| ☐ Y ☐ N Family history of heart disease | ☐ Y ☐ N Surgeries | ☐ Y ☐ N Osteoporosis |
| ☐ Y ☐ N Heart Attack | ☐ Y ☐ N Hospitalization | ☐ Y ☐ N Thyroid disease |
| ☐ Y ☐ N Artificial joint | ☐ Y ☐ N Diabetes | ☐ Y ☐ N Asthma |
| ☐ Y ☐ N Stomach problems or ulcer | ☐ Y ☐ N Family history of diabetes | ☐ Y ☐ N Hepatitis |
| ☐ Y ☐ N Heart defects | ☐ Y ☐ N Tumors or cancer | ☐ Y ☐ N Sexual transmitted disease |
| ☐ Y ☐ N Heart murmur | ☐ Y ☐ N Chemotherapy | ☐ Y ☐ N Herpes |
| ☐ Y ☐ N Rheumatic fever | ☐ Y ☐ N Radiation | ☐ Y ☐ N Canker or cold sores |
| ☐ Y ☐ N Skin disease | ☐ Y ☐ N Arthritis, rheumatism | ☐ Y ☐ N Anemia |
| ☐ Y ☐ N Hardening of arteries | ☐ Y ☐ N Emphysema or other lung disease | ☐ Y ☐ N Liver disease |
| ☐ Y ☐ N High blood pressure | ☐ Y ☐ N Kidney or bladder disease | ☐ Y ☐ N Eye disease |
| ☐ Y ☐ N Seizures | ☐ Y ☐ N Stroke | ☐ Y ☐ N Transplants |
| | | ☐ Y ☐ N Tuberculosis |

**This information will not be released unless specifically authorized by patient.**

☐ Y ☐ N AIDS/HIV ☐ Y ☐ N Anxiety ☐ Y ☐ N Depression ☐ Y ☐ N Treatment for emotional condition

**IV. Are you allergic to or have you had a reaction to any of the following? (*Please check Yes or No for each*)**

| | | |
|---|---|---|
| ☐ Y ☐ N Aspirin | ☐ Y ☐ N Valium | ☐ Y ☐ N Tetracycline |
| ☐ Y ☐ N Darvon | ☐ Y ☐ N Demerol | ☐ Y ☐ N Vicodin |
| ☐ Y ☐ N Codeine | ☐ Y ☐ N Penicillin | ☐ Y ☐ N Percodan |
| ☐ Y ☐ N Latex | ☐ Y ☐ N Food | ☐ Y ☐ N Nitrous oxide |
| ☐ Y ☐ N Local anesthetic (Novocain or Xylocaine) | ☐ Y ☐ N Erythromycin | ☐ Y ☐ N Metal |

Others _____

**V. Are you taking or have you taken any of the following in the last three months? (*Please check Yes or No for each)***

| | | |
|---|---|---|
| ☐ Y ☐ N Recreational drugs | ☐ Y ☐ N Tobacco in any form | ☐ Y ☐ N Antibiotics |
| ☐ Y ☐ N Over-the-counter medicine | ☐ Y ☐ N Alcohol | ☐ Y ☐ N Supplements |
| ☐ Y ☐ N Weight loss medications | ☐ Y ☐ N Bisphosphonate (Fosamax) | ☐ Y ☐ N Aspirin |
| ☐ Y ☐ N Cortico – Steroids | | |

Please list all medications you are currently taking _____

**VI. Do you or have you had any of the following habits? (*Please check Yes or No for each)***

| | | |
|---|---|---|
| ☐ Y ☐ N Lip Sucking/Biting | ☐ Y ☐ N Nail Biting | ☐ Y ☐ N Mouth Breather |
| ☐ Y ☐ N Clenching/Grinding Teeth | ☐ Y ☐ N Tongue Thrusting | ☐ Y ☐ N Thumb/Finger Sucking |
| ☐ Y ☐ Prolonged Bottle/Pacifier | | |

**VII. Women only (*Please check Yes or No for each)***

☐ Y ☐ N **Are you or could you be pregnant? If YES, due date?** _____

☐ Y ☐ N **Are you nursing?**

☐ Y ☐ N **Are you taking birth control pills?**

**VIII. All patients (*Please check Yes or No for each)***

☐ Y ☐ N **Do you have or have you had any other diseases or medical problems NOT listed on this form? If YES, explain**

_____

☐ Y ☐ N **Have you ever been pre-medicated for dental treatment? If YES, why**

_____

☐ Y ☐ N **Do you smoke?**

☐ Y ☐ N **Do you like your smile?**

**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's Signature _____Date_____
Physician's Name_____Phone Number_____

## Signature

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.
I hereby authorize the release of any information related to insurance claims. I consent to the examination by the doctor and I authorize payment of any insurance benefits to the office.
I understand where appropriate, credit bureau reports may be obtained.

Name of person filling out this form _____ Date _____

CLICK TO SUBMIT