Back Mountain Dental
JAMES C. DEFINNIS, DMD

HEALTH HISTORY FORM

Date _____ Name _____

Home Phone (____)_____ Cell (____)_____ Work (____)_____

Street Address _____ City _____ State _____ Zip Code _____

Mailing Address if different than above:

Street Address _____ City _____ State _____ Zip Code _____

Date of Birth _____ Sex ☐ M ☐ F Occupation _____ Social Security# _____

Email Address: _____

Preferred Pharmacy: _____ Pharmacy Phone # _____

Emergency Contact Name: _____ Phone Number: _____ Relationship _____

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

How did you hear about Back Mountain Dental? Google ☐ Yellow book ☐ Times Leader ☐ Website ☐ Billboard ☐

Friend/Family Member ☐ _____

DENTAL INFORMATION Signature of Responsible Party

	YES	NO	UNKNOWN
Do your gums bleed when you brush?	☐	☐	☐
Have you ever had orthodontic treatment?	☐	☐	☐
Do you have headaches, earaches or neck pains?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Do you wear removable/fixed dental appliances?	☐	☐	☐
Are you aware of loose teeth or broken fillings?	☐	☐	☐
Are your gums swollen or tender?	☐	☐	☐
Are you a mouth breather?	☐	☐	☐
Do you or have you been told you grind your teeth?	☐	☐	☐
Do you frequently get blisters on lips or mouth?	☐	☐	☐

	YES	NO	UNKNOWN
Do you ever get a burning sensation on tongue?	☐	☐	☐
Do you have pain when brushing?	☐	☐	☐
Do you chew on one side of mouth?	☐	☐	☐
Do you get clicking or popping of your jaw?	☐	☐	☐
Do you bite your nails or foreign objects?	☐	☐	☐
Do you get jaw pain or tiredness?	☐	☐	☐
Does food collect between your teeth?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets, or pressure?	☐	☐	☐
Do you have a family history of Periodontal Disease?	☐	☐	☐
Have you been told you have periodontal (gum) disease ?	☐	☐	☐

Have you had any problems associated with previous dental treatment or past dental experiences?

If so explain: _____

Oral habits (Circle all that apply)

Tongue/lip piercing Ice chewing Musical instrument with mouthpiece Using teeth as a tool

What fluoride products do you use/consume? (Circle all that apply) Toothpaste Water Rinses Other _____

What are the three most important factors you desire from your dental office?

1._____ 2._____ 3._____

How do you feel about the appearance of your teeth? _____

Do you have any problems with bad breath? _____

How often do you floss? _____ /day

How often do you brush? _____ /day

How often do you have dental checkups? _____

Please indicate the level of dental care you would like us to provide:

Emergency care as needed ☐
Routine exam and preventive care ☐
Comprehensive care, optimal dental health and appearance ☐
Consultation to solve a specific problem ☐

MEDICAL INFORMATION

Physician(s) _____
Name Phone

Address _____
City/State/Zip

	YES	NO	UNKNOWN
Are you in good health?	☐	☐	☐
Have there been any changes in your health within the past year?	☐	☐	☐

Are you under the care of a physician? If so, what are the conditions being treated? _____

Date of last exam _____

Do you consume snacks/beverages containing sugar between meals? YES / NO

How many times per day? _____

	YES	NO	UNKNOWN
Have you ever had any serious illness, operation, or been hospitalized in the past five years?	☐	☐	☐

If so, what was the illness or problem? _____

What is your alcohol consumption history?

	Lifetime abstainer:	Never had ≥12 drinks in any year of life
	Former drinker:	Consumed ≥ 12 drinks in any 1 year, but not in past year
	Light drinker:	Consumed ≥ 12 drinks in past year and <3 per week on average
	Moderate drinker:	Consumed 3 to <14 drinks per week on average in past year
	Heavy drinker:	Consumed ≥2 to <3 drinks per day on average in past year
	Abuser:	Consumed ≥3 drinks per day on average in past year

What is your history of tobacco use?

	Cigarette, Cigar or Pipe Use				*Smokeless Tobacco Use*		
	Never smoked cigarettes	**Age began**	***Year Quit***		***Never used smokeless tobacco***	***Age began***	***Year Quit***
	Former smoker				Former user		
	<10 per day				Occasional user		
	≥10 per day				Daily user		

Are you taking any medications (Prescription or Over-the-Counter)?

Name of Drug	Purpose	Date

Are you allergic to or have you had a reaction to?

	YES	**NO**	**UNKNOWN**
Local Anesthetics	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐	☐
Sulfa Drugs	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Latex	☐	☐	☐
Iodine	☐	☐	☐
Hay fever/seasonal	☐	☐	☐
Metal	☐	☐	☐

Please list any drugs or medicines that you cannot or prefer to not take because of allergies or side-effects especially Antibiotics for infections, analgesics for pain, and anesthetics. _____

What is your preferred drug for mild and/or severe pain? _____

What is your preferred antibiotic for an infection? _____

Please (x) a response to indicate if you have or have had any of the following diseases or problems

	YES	NO	UNKNOWN
Abnormal Bleeding	☐	☐	☐
Controlled? (Circle one): Good Fair Poor			
AIDS or HIV	☐	☐	☐
Anemia	☐	☐	☐
Herpes	☐	☐	☐
Arthritis	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐
Asthma	☐	☐	☐
Blood Transfusion	☐	☐	☐
If yes, date _____			
Cancer/Chemotherapy/Radiation	☐	☐	☐
Cardiovascular diseases?	☐	☐	☐
Angina Pectoris_____			
Heart Murmur_____			
Bypass Surgery _____			
Mitral Valve Prolapse_____			
Pacemaker_____			
Rheumatic Fever _____			
Artificial Valves_____			
Heart Attack _____			
Date _____			
Chest Pain/Shortness of breath upon			
Exertion	☐	☐	☐
Chronic Pain	☐	☐	☐
G.E. Reflux, persistent heartburn,			
or Gastrointestinal Disease	☐	☐	☐
Hemophilia	☐	☐	☐
Hepatitis, Jaundice, or Liver Disease	☐	☐	☐
High/ Low Blood Pressure	☐	☐	☐
Recurrent Infection			
If yes, what type of infection_____			
Diabetes	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Dry Mouth	☐	☐	☐

	YES	NO	UNKNOWN
Epilepsy	☐	☐	☐
Joint Replacement	☐	☐	☐
Eating disorder			
If yes, please specify _____			
Disease, drug or			
Radiation-induced immunosuppression	☐	☐	☐
Mental Health disorder	☐	☐	☐
Night sweats/ Menopausal	☐	☐	☐
Neurological disorders	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands	☐	☐	☐
Respiratory problems	☐	☐	☐
If yes, please specify			
Emphysema _____			
Bronchitis, etc._____			
Severe headaches/migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Sinus Trouble	☐	☐	☐
Sores or ulcers in the mouth	☐	☐	☐
Stroke	☐	☐	☐
If yes, date _____			
Systemic Lupus Erythematous	☐	☐	☐
Tuberculosis	☐	☐	☐
Thyroid problems	☐	☐	☐
Ulcers	☐	☐	☐
Excessive urination/thirst	☐	☐	☐
Do you have any disease not listed above?			
Is there anything else you think we should know about?			
Please explain: _____			
Have you ever been told you needed to			
Pre-medicate for dental treatment?	☐	☐	☐
Are you pregnant?	☐	☐	☐
Are you planning to be pregnant?	☐	☐	☐

Please feel free to add any additional information you would like us to know about your medical or dental care:

_____

_____

I certify that I have read and understand the above. 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 because of errors or omission that I may have made in the completion of this form.

_____

SIGNATURE OF PATIENT/LEGAL GUARDIAN

_____

DATE

I have reviewed the attached medical/dental history and have noted any changes

Date Comments/Changes

Signature of patient (or guardian) Signature of Dentist/Hygienist

Date Comments/Changes

Signature of patient (or guardian) Signature of Dentist/Hygienist

Date Comments/Changes

Signature of patient (or guardian) Signature of Dentist/Hygienist

Date Comments/Changes

Signature of patient (or guardian) Signature of Dentist/Hygienist

Date Comments/Changes

Signature of patient (or guardian) Signature of Dentist/Hygienist

Date Comments/Changes

Signature of patient (or guardian) Signature of Dentist/Hygienist

Date Comments/Changes

Signature of patient (or guardian) Signature of Dentist/Hygienist

Date Comments/Changes

Signature of patient (or guardian) Signature of Dentist/Hygienist

SMILE EVALUATION

Do you like the appearance of your teeth, your smile? ☐YES ☐NO

If not, explain, _____

Do you like the color and shape of your teeth? ☐YES ☐NO

If not, explain, _____

Are there old fillings or dental work that you don't like? ☐YES ☐NO

If not, explain, _____

If you could, what would you change about the appearance of your teeth? _____

_____

Would you like us to tell you about: ☐Deep Bleaching ☐ Invisalign ☐Veneers ☐Smile Makeover

DENTAL INSURANCE INFORMATION

Insured is: ☐ Self ☐ Husband ☐ Wife ☐ Mother ☐ Father ☐Other

Employee's Name _____ Employee's Social Security #_____

Employer_____ Employer's Address_____

Insurance Co._____ Group# _____

Employee's Date of Birth _____/____/_____

Are you covered with a second insurance company? ☐YES ☐NO

If yes, Employee's name _____ Employee's Social Security #_____

Employer_____ Employer's Address_____

Insurance Co._____ Group# _____

Employee's Date of Birth _____/____/_____

I understand that I am financially responsible for care provided and that insurance is considered a method of reimbursement but is not a substation for payment. I authorize my signature to be "on file" for the processing of dental claims on my or my family's behalf and authorize benefits to be paid directly to Back Mountain Dental, Inc. I understand that deductibles, co-payments and non-covered services are **my responsibility to pay at the time of service**. A $35 statement fee will be added to any balance over 30 days old.

X _____ Date____/____/_____

Patient or parent/guardian

The highest compliment our patients can give us is the referral of their friends and family.
Thank you for your trust!