PATIENT INFORMATION

CHART #_____

FIRST NAME_____ INT_____ LAST NAME_____ DOB _____/_____/_____

HOME ADDRESS_____ APT# _____ CITY_____ STATE_____ ZIP_____

HOME PHONE ( )_____ CELL PHONE ( )_____ WORK PHONE ( )_____

DL#_____ SEX (M) (F)

EMPLOYER_____ POSITION_____

EMPLOYER ADDRESS_____ EMPLOYER PHONE ( )_____

IN CASE OF EMERGENCY, PLEASE CONTACT_____ PHONE ( )_____

YOUR PRIVACY IS IMPORTANT TO US

How Would You Like Us To Communicate With You?

So that we are in compliance with HIPAA & the ADA, please check the box/boxes below giving consent to the dental practice or its service provider to contact you by mail, email, phone and/or text message regarding appointment reminders, information about treatments, payments, insurance, & other types of communication.

Please notify our office immediately if your contact information changes.

<u>Check & Complete All That Apply (Please Print Clearly)</u>

◯ **Contact me by Mail at the following address_____**

◯ **Contact me by Email at the following address_____**

◯ **Contact me by Phone/Text Message at the following number/s:**

Cell _____
Home _____
Work _____

Print Name_____ Date_____

Signature_____

HEALTH HISTORY

PATIENT NAME_____ **CHART #**_____

DATE _____

AGE _____ SEX M / F

HEIGHT_____ WEIGHT_____ LBS.

In case of an *emergency*, contact (person) _____ phone # ( ) _____-_____

INSTRUCTIONS:

Answer all questions and fill in the blank spaces when indicated.

Answers to the following questions are for our records only and will be kept confidential.

Why are you here today? _____

When was your last visit to a dental office? _____/_____/_____

When were your last x-rays taken? _____/_____/_____

Are those x-rays available? Yes_____ No_____

If YES, please write down PRIOR DENTIST NAME_____
and PHONE NUMBER: (_____)_____

	YES	NO
1. Are you in poor health?	_____	_____
2. Has there been any change in your general health within the past year?.....	_____	_____
3. My last physical was on_____		
4. Are you currently under the care of a physician?	_____	_____
A. If so, what is the condition being treated? _____		
_____		
5. The name, address and phone number of my physician:		
_____		
_____		
6. Have you had any serious illness or operation?	_____	_____
A. if so, what was the illness or operation? _____		
_____		
7. Have you been hospitalized or had serious illness within the past five years.....	_____	_____
A. If so, what was the problem? _____		
_____		
8. Do you have or have you had any of the following Diseases or problems:		
A. Damaged heart valves or artificial heart valves.....	_____	_____
B. Congenital heart lesions or murmurs.....	_____	_____
C. Cardiovascular disease (heart trouble, heart attack, Coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke).....	_____	_____
1) Do you have pain in the chest upon exertion.....	_____	_____
2) Are you ever short of breath after mild exercise.....	_____	_____
3) Do your ankles swell?	_____	_____
4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep?.....	_____	_____
5) Do have a cardiac pacemaker?	_____	_____

	YES	NO
D. Sinus trouble……	_____	_____
E. Asthma……	_____	_____
F. Allergy……	_____	_____
G. Hives or skin rash……	_____	_____
H. Fainting spells or seizures……	_____	_____
I. Diabetes……	_____	_____
1) Do you urinate (pass water) more than 6 times a day? ...	_____	_____
2) Are you thirsty much of the time?	_____	_____
3) Does your mouth frequently become dry?	_____	_____
J. Hepatitis, jaundice or liver disease……	_____	_____
K. Arthritis……	_____	_____
L. Inflammatory rheumatism (painful, swollen joints)……	_____	_____
M. Stomach ulcers……	_____	_____
N. Kidney trouble……	_____	_____
O. Tuberculosis……	_____	_____
P. Do you have a persistent cough or cough up blood……	_____	_____
Q. Low blood pressure……	_____	_____
R. Venereal disease……	_____	_____
S. Do you have a prosthetic hip ____joint prosthetic _____ Implants ____ Bone plates___ or screws ____other_____		
9. Have you had abnormal bleeding associated with previous Extractions, surgery, or trauma……	_____	_____
A. Do you bruise easily?	_____	_____
B. Have you ever required a blood transfusion?	_____	_____
If so, explain the circumstances	_____	_____
10. Do you have any blood disorder such as anemia?	_____	_____
11. Have you had surgery or x-ray treatment for tumor, growth, or other condition of your mouth or lips……	_____	_____
12. Are you taking any of the following?	_____	_____

If yes, indicate which.

A. Antibiotics or sulfa drugs____
B. Anticoagulants (blood thinners)____
C. Medicine for high blood pressure____
D. Cortisone (Steroids)____
E. Tranquilizers____ Antihistamine____ Aspirin____
F. Insulin, tolbutamide (orinase) or similar drugs___
G. Digitalis or drugs for heart trouble____Nitroglycerin____
H. Oral contraceptive or other hormonal therapy____
I. Other drug or medicine_____

13. Are you taking or scheduled to begin taking either of the Medications, alendronate(Fosamax) or risedronate(Actonel) for osteoporosis or Paget's disease?.....	_____	_____
14. Since 2001, were you treated or are you presently Scheduled to begin treatment with the intravenous Biphosphonates (Aredia or Zometa) for bone pain, Hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ...	_____	_____

Date treatment began:_____

	YES	NO
15. Are you allergic or have you reacted adversely to any of the following……	_____	_____
Local anesthetics_____		
Penicillin or other antibiotics____		
Sulfa drugs_____		
Barbiturates, sedatives or sleeping pills_____		
Aspirin____Iodine____ Codeine or other narcotics____		
Are you allergic to latex or rubber products……..	_____	_____
Other allergies_____		
16. Have you taken the diet medication Redux(Fen-Phen)?.....	_____	_____
17. Do you have any disease, condition, or problem not listed above that you think I should know about……	_____	_____
18. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation……	_____	_____
19. Are you wearing contact lenses……	_____	_____
20. Have you ever had any of the following conditions…….	_____	_____
Herpes____ Hepatitis_____ Tuberculosis____HIV/AIDS _____		
21. Are you pregnant……	_____	_____
22. Do you have any problems associated with your menstrual period……	_____	_____
23. Are you nursing?	_____	_____
24. Have you had any serious trouble associated with any previous dental treatment?	_____	_____
If so, explain_____		
25. How often do you brush your teeth?____When?_____		
26. Do you use dental floss?	_____	_____
27. Do your gums bleed or hurt?	_____	_____
How often? _____		
28. Are any of your teeth sensitive to: Hot_____ Cold_____		
Sweets_____ Pressure_____		
29. Does food get caught in your teeth?	_____	_____
30. Do you have frequent headaches_____ neck aches_____		
Or shoulder aches_____.....	_____	_____
31. Do you clench or grind your teeth?	_____	_____
32. Have you experienced any pain or soreness in the muscles of your face or around your ear?.....	_____	_____
33. Does your jaw click or pop?	_____	_____

FOLLOW UP to Medical History by DENTIST ONLY_____

_____

_____

_____

I hereby certify that I have read the foregoing and have filled out this health questionnaire completely. I have advised you of all medical problems of which I am aware. I further certify that I, the undersigned, consent to the performing of x-rays and examination.

SIGNATURE OF **PATIENT** OR **GUARDIAN** if patient is a minor X_____ DATE_____

SIGNATURE OF **DENTIST** X_____ DATE_____