Health History Information

Patient Name____________________________________ Date ____________________
Reason for today's visit: ________________________________ Date of Last Dental Cleaning Visit: ____________

What would you like to improve about your smile?____

Have you ever had any of the following? Please check those that apply:

☐ Acid Reflux
☐ AIDS/HIV
☐ Allergy - Codeine
☐ Allergy - Penicillin
☐ Allergy - Other
Type: ________
Type: ________
☐ Anemia
☐ Arthritis
☐ Artificial Joints
Type: ___________
Date: ___________
☐ Asthma
☐ Blood Disease
☐ Cancer: Type: _____

☐ Dental Anxiety
☐ Diabetes Type 1 or 2
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Headaches/Migraines
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis Type____
☐ High Blood Pressure
☐ Jaundice

☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Radiation Treatment
☐ Recreational Drugs
☐ Marijuana
☐ Other________
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Sleep Apnea

☐ Snoring
☐ S.T.D: Type: _______
☐ Stroke
☐ Tobacco - Smoke
☐ Tobacco - Snuff
☐ Teeth Grinding/ Clench
☐ Thyroid
☐ Tuberculosis
☐ Tumors
☐ Ulcer
OTHER:
☐ _______________
☐ _______________

PRE-MEDICATION REQUIRED? ☐ Yes ☐ No Reason: ________________ Prescription: _________________

****WOMEN ONLY**: Are you pregnant? Yes____ No ____ If yes, Due Date: _______________

- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:

____

- List of Current Medications:

____
____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:

____

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:____
- Name of Physician: ____ Phone:____________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during such Dental care to the third party and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X____ Date: ____/____/_____ Relationship to Patient: ____________________
Signature of patient or legal guardian