# Welcome

*Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.*

Patient # _____

SS#/SIN _____

Date _____

## Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Email _____ Cell Phone _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School/College _____ City _____ State/Prov. _____ ☐ Full Time ☐ Part Time

Patient or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

## Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SS#/SIN _____

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

## Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

Over Please

**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 EVER EXPERIENCED ANY OF THE FOLLOWING?** (Please circle Yes or No for each)

| | | | | | |
|---|---|---|---|---|---|
| Yes / No | Chest pain (angina) | Yes / No | Blood in stools | Yes / No | Frequent vomiting |
| Yes / No | Fainting spells | Yes / No | Diarrhea or constipation | Yes / No | Jaundice |
| Yes / No | Recent significant weight loss | Yes / No | Frequent urination | Yes / No | Dry mouth |
| Yes / No | Fever | Yes / No | Difficulty urinating | Yes / No | Excessive thirst |
| Yes / No | Night sweats | Yes / No | Ringing in ears | Yes / No | Difficulty swallowing |
| Yes / No | Persistent cough | Yes / No | Headaches | Yes / No | Swollen ankles |
| Yes / No | Coughing up blood | Yes / No | Dizziness | Yes / No | Joint pain or stiffness |
| Yes / No | Bleeding problems | Yes / No | Blurred vision | Yes / No | Shortness of breath |
| Yes / No | Blood in urine | Yes / No | Bruise easily | Yes / No | Sinus problems |

Other: _____

**III. HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING?** (Please circle Yes or No for each)

| | | | | | |
|---|---|---|---|---|---|
| Yes / No | Heart disease | Yes / No | AIDS/HIV | Yes / No | Psychiatric care |
| Yes / No | Family history of heart disease | Yes / No | Surgeries | Yes / No | Osteoporosis |
| Yes / No | Heart attack | Yes / No | Hospitalization | Yes / No | Thyroid disease |
| Yes / No | Artificial joint | Yes / No | Diabetes | Yes / No | Asthma |
| Yes / No | Stomach problems or ulcers | Yes / No | Family history of diabetes | Yes / No | Hepatitis |
| Yes / No | Heart defects | Yes / No | Tumors or cancer | Yes / No | Sexual transmitted disease |
| Yes / No | Heart murmurs | Yes / No | Chemotherapy | Yes / No | Herpes |
| Yes / No | Rheumatic fever | Yes / No | Radiation | Yes / No | Canker or cold sores |
| Yes / No | Skin disease | Yes / No | Arthritis, rheumatism | Yes / No | Anemia |
| Yes / No | Hardening of arteries | Yes / No | Emphysema or other lung disease | Yes / No | Liver disease |
| Yes / No | High blood pressure | Yes / No | Kidney or bladder disease | Yes / No | Eye disease |
| Yes / No | Seizures | Yes / No | Stroke | Yes / No | Transplants |
| Yes / No | Cosmetic surgery | Yes / No | Eating disorders | Yes / No | Tuberculosis |

Other: _____

**IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING?** (Please circle Yes or No for each)

| | | | | | |
|---|---|---|---|---|---|
| Yes / No | Aspirin | Yes / No | Valium or sedatives | Yes / No | Codeine or other opioids |
| Yes / No | Penicillin or other antibiotics | Yes / No | Latex | Yes / No | Food |
| Yes / No | Nitrous oxide | Yes / No | | | Local anesthetic |
| Yes / No | Metal | | | | |

Others: _____

**V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS?** (Please circle Yes or No for each)

| | | | | | |
|---|---|---|---|---|---|
| Yes / No | Recreational drugs | Yes / No | Tobacco in any form | Yes / No | Antibiotics |
| Yes / No | Over-the-counter medicines | Yes / No | Alcohol | Yes / No | Supplements |
| Yes / No | Weight loss medications | Yes / No | Bisphosphonate (Fosamax) | Yes / No | Aspirin |
| Yes / No | Anti-Depressants | Yes / No | Herbal supplements | | |

Yes / No Opioids (e.g., Norco, Vicodin, Percocet, Percodan) If YES, please explain reason: _____

Please list all prescription medications: _____

**VI. WOMEN ONLY** (Please circle Yes or No for each)

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?

**VII. ALL PATIENTS** (Please circle Yes or No for each)

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?**

*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: _____

**Whom would you like us to contact in case of an emergency?):**

**Name:** _____ **Relationship:** _____ **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 | DENTIST INITIALS |
|---|---|---|---|
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