Health History Form

Mr. Mrs. Miss Ms. ____________________________Phone#__________________Birthdate_____-______-_____ SSN# ____________

Home Address ____Apt/Suite#_______City_______________State_____Zip_______________

Email Address: ______________________________Dental Insurance_____________ Group/Plan No.________ Employer________________

How did you find out about our office: _______________ What is the reason of your visit today?______________________________________

Do you have any present dental complaints? ______ Any Pain/sensitivity? _______Please explain: ___________________________________

When was your last full mouth xrays taken? ___________________When was your last check up and cleaning?_________________________

Person to contact in case of emergency: _______________________Phone:____________________Relationship:______________________

Medical History

Physician: ____________________ Address: ____Phone: ________________

Are you in good health? _____ If no, explain ____

Do you have an existing illness?_____ If yes, explain____

Have you been hospitalized in the past two years? _____ If yes, explain____

Do you bleed excessively when cut? ______ Do you smoke? ______ If yes, how much? ____

Are you currently taking medication, pills or drugs?_____ If yes, please list:____

Were you ever instructed to be pre-medicated before dental visits? ________ If yes, explain__________________________________

Do you now have, or have you had any of the following? (If yes, describe under remarks)

	Yes	No		Yes	No
Heart Disease	□	□	Liver Disease	□	□
High Blood Pressure	□	□	Kidney Disease	□	□
Blood Disease	□	□	Hepatitis A B C	□	□
Rheumatic Fever	□	□	Asthma	□	□
Heart Murmur	□	□	Tuberculosis	□	□
Diabetes	□	□	Artificial Joint/Pacemaker	□	□
Stroke	□	□	**Allergic** to Penicillin	□	□
Epilepsy	□	□	Ibuprofen	□	□
VD	□	□	Codeine	□	□
Arthritis	□	□	Tetracycline	□	□
Tumor History	□	□	Latex, Metals, Plastics	□	□
Lupus	□	□	Local Anesthetics	□	□
AIDS/HIV Positive	□	□	Other Medications	□	□
			Explain: ____________________________		
Nervous Disorders	□	□	Are you Pregnant?	□	□
Radiation Treatment	□	□	Have you ever use Fen-Phen?	□	□

Remark **Reviewed:**

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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical and insurance status.

Signature of Patient (Parent or Guardian if patient is a minor) ___________________________________ **Date:** ______________