PATIENT HEALTH INFORMATION

Name: _____ **Date:** _____

	Yes	No
Are you in good health?	☐	☐
Have there been any changes in your general health within the past year?	☐	☐
Date of your last physical exam: _____		
Physician's name: _____		
Have you ever been hospitalized for any surgical operation or serious illness? Please explain below:	☐	☐
_____		
Are you taking any medications, including non-prescription medications? Please list all below:	☐	☐
_____		
_____		
_____		

Women Only:

	Yes	No
Are you pregnant or think you may be pregnant?	☐	☐
Are you nursing?	☐	☐
Are you or have you ever taken any bisphosphonate medications i.e. Actonel, Boniva, Fosamax, Relast?	☐	☐
Are you taking birth control pills?	☐	☐

	Yes	No
Do you bruise easily?	☐	☐
Have you ever had a blood transfusion?	☐	☐
Do you use tobacco?	☐	☐
Have you had a recent weight loss?	☐	☐
Have you had any abnormal bleeding?	☐	☐

Are you allergic to or have you had reactions to:	Yes	No
Local anesthetics like novocaine, lidocaine	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates, sedatives or sleeping pills	☐	☐
Aspirin	☐	☐
Iodine	☐	☐
Any metals (e.g., nickel, mercury, etc.)	☐	☐
Latex / rubber	☐	☐
Other (please list) _____		

Do you have or have you ever had the following:	Yes	No
Rheumatic heart disease or rheumatic fever	☐	☐
Heart defect, heart murmur, mitral valve prolapse	☐	☐
Heart trouble, heart attack or angina	☐	☐
Chest pain	☐	☐
Shortness of breath	☐	☐
High/low blood pressure	☐	☐
Congenital heart problem	☐	☐
Swelling of feet, ankles, hands	☐	☐
Hepatitis A ☐ B ☐ C ☐, jaundice or liver disease	☐	☐
Stroke	☐	☐
Sinus trouble	☐	☐
Lung, breathing problems or asthma	☐	☐
Lupus (SLR)	☐	☐

	Yes	No
Hives or skin rash	☐	☐
Diabetes	☐	☐
Aids or HIV infection	☐	☐
Thyroid problems	☐	☐
Allergies	☐	☐
Arthritis or rheumatism	☐	☐
Joint replacement or implant	☐	☐
Stomach ulcer	☐	☐
Kidney trouble	☐	☐
Tuberculosis	☐	☐
Pacemaker/other electronic device	☐	☐
Persistent cough	☐	☐
Cough that produces blood	☐	☐
Chemotherapy or radiation	☐	☐
Epilepsy or seizures	☐	☐
Anemia	☐	☐
Glaucoma	☐	☐
Nervousness	☐	☐
Tumors	☐	☐
Back problems	☐	☐
Chemical dependency	☐	☐
Steroid treatment	☐	☐
Cold sores/fever blisters	☐	☐
Eating disorders	☐	☐
Any disease/condition not noted above, please explain:		

PATIENT HEALTH INFORMATION (Continued)

When was your last dental visit? _____ What was done then? _____

How often did you visit the dentist before then? _____

Previous dentist (name and location) _____

Have you had a complete series of x-rays taken? When _____ Where _____

How often do you brush your teeth? _____ How often do you floss your teeth? _____

	YES	NO
Do your gums bleed while brushing or flossing?	☐	☐
Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
Are your teeth sensitive to sweet or sour foods/liquids?	☐	☐
Do you feel pain in any of your teeth?	☐	☐
Do you have frequent headaches?	☐	☐
Do you clench or grind your teeth?	☐	☐

	YES	NO
Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐
Have you ever had periodontal treatment?	☐	☐
Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐

Reason for today's office visit

_____

_____

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information, and that all questions have been accurately answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any record of treatment and x-rays to other health practitioners or insurance companies, only in regards to my care or to payment. I authorize and request my insurance company pay directly to the dentist any insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than estimated. I agree to be responsible for payment of all services rendered on my behalf or my dependents, regardless of my insurance coverage. In order to avoid an appointment cancellation fee, I agree to give at least 24 hours advance notice if I am unable to keep a scheduled appointment.

_____ _____

Signature of patient (or parent if minor) Date