

Health History

Patient Information

Date _____

Name _____ Date of Birth _____ Age _____

Home Address _____ City _____ Zip _____

Occupation _____ Married yes no Phone # _____ Cell # _____

How did you hear about us _____ Email _____

Who is responsible for this account: Name _____ Phone # _____

Address _____ Occupation _____ Employer _____

Reason for visit: Complete Exam Emergency 6 Month Checkup Other _____

Oral Health Information

Last dental exam & x-rays _____

Name of previous Dentist _____

Are you having any dental pain yes no

Are your teeth sensitive to hot/cold/sweet/biting yes no

Do your gums bleed when brushing/flossing yes no

Do you want to replace any missing teeth yes no

Are you unhappy with your smile yes no

Are you interested in whitening your teeth yes no

Do you clench or grind your teeth yes no

Do you have TMJ problems/popping yes no

Are you taking any medications (including contraceptives)? yes no Please list: _____

Medical Information

Name of Physician _____

Ever had serious injury/illness or surgery yes no

Describe _____

Ever had excessive bleeding after extraction yes no

Are you allergic to any medications yes no

Please list _____

Do you Smoke yes no If yes, how much _____

WOMEN: Are you or could you be pregnant yes no

If yes, how far along _____

Are you breastfeeding yes no

Do you have, or have you ever had, any of the following:

Joint replacement	<input type="checkbox"/> yes <input type="checkbox"/> no	Diabetes	<input type="checkbox"/> yes <input type="checkbox"/> no	Blood disorder	<input type="checkbox"/> yes <input type="checkbox"/> no
Osteoporosis	<input type="checkbox"/> yes <input type="checkbox"/> no	Cancer	<input type="checkbox"/> yes <input type="checkbox"/> no	Headaches/migraines	<input type="checkbox"/> yes <input type="checkbox"/> no
High Blood Pressure	<input type="checkbox"/> yes <input type="checkbox"/> no	Fainting or dizziness	<input type="checkbox"/> yes <input type="checkbox"/> no	Thyroid condition	<input type="checkbox"/> yes <input type="checkbox"/> no
Heart Disease	<input type="checkbox"/> yes <input type="checkbox"/> no	Epilepsy/Seizures	<input type="checkbox"/> yes <input type="checkbox"/> no	Kidney disease	<input type="checkbox"/> yes <input type="checkbox"/> no
Congenital heart defect	<input type="checkbox"/> yes <input type="checkbox"/> no	Excessive bleeding	<input type="checkbox"/> yes <input type="checkbox"/> no	Pacemaker	<input type="checkbox"/> yes <input type="checkbox"/> no
Dental pre-medication	<input type="checkbox"/> yes <input type="checkbox"/> no	Hepatitis/Liver disorder	<input type="checkbox"/> yes <input type="checkbox"/> no	Radiation therapy	<input type="checkbox"/> yes <input type="checkbox"/> no
Stroke	<input type="checkbox"/> yes <input type="checkbox"/> no	Autoimmune disorder	<input type="checkbox"/> yes <input type="checkbox"/> no	Digestive problems	<input type="checkbox"/> yes <input type="checkbox"/> no
Asthma	<input type="checkbox"/> yes <input type="checkbox"/> no	Tuberculosis	<input type="checkbox"/> yes <input type="checkbox"/> no	Nervous Disorder	<input type="checkbox"/> yes <input type="checkbox"/> no
Respiratory disorder	<input type="checkbox"/> yes <input type="checkbox"/> no	HIV/AIDS	<input type="checkbox"/> yes <input type="checkbox"/> no	Difficulty breathing	<input type="checkbox"/> yes <input type="checkbox"/> no

Do you have anything else we have not asked? _____

Consent for Treatment

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding medical condition. I shall inform the dentist and staff of any changes at the next appointment without fail. Payment for all treatment and services rendered are my responsibility.

X _____ Date _____ Relation _____
Patient or legal Guardian Relationship to minor

HIPPA Acknowledgement

By signing below I acknowledge that I was offered a copy of this office's state and federal Notice of Privacy Practices and had full opportunity to consider the contents of the consent. I understand that by signing, I am confirming my written permission for the disclosure of my protected health information, as described in the forms.

X _____ Date _____ Relation _____
Patient or legal Guardian Relationship to minor