

Welcome!

Section I: **Patient Information** **Date** _____

Name: _____ I prefer to be called: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____
The best time to contact me is: _____ · A.M. · P.M. On my · Home · Work · Cell
Date of Birth: _____ Social Security Number: _____ Drivers License #: _____
Check Appropriate Box: · Minor · Single · Married · Widowed · Separated · Divorced
Spouse or Parent's Name: _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

Email Address _____

Section II **Responsible Party**

Relationship to Patient: · Self · Spouse · Parent · Other

Name: _____ Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (____) _____

Employer _____ Work Phone (____) _____ SSN# _____

Section III **Insurance Information**

Name of Insured _____ DOB _____ Relationship to Patient _____

SSN#: _____ Name of Employer: _____ Work Phone: (____) _____

Address of Employer: _____ City _____ State: _____ Zip _____

Insurance Company _____ Grp # _____ ID# _____

Ins Co Address: _____ INS Co. Phone: _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? · Yes · No IF YES, COMPLETE THE FOLLOWING -----

Name of Insured _____ DOB _____ Relationship to Patient _____

SSN#: _____ Name of Employer: _____ Work Phone: (____) _____

Address of Employer: _____ City _____ State: _____ Zip _____

Insurance Company _____ Grp # _____ ID# _____

Ins Co Address: _____ INS Co. Phone: _____

Health History

1. Have you ever had any serious illness or operation?Yes No
2. Are you now under the care of a physician?.....Yes No
3. Are you taking any medications, drugs or herbs?Yes No
If so what? _____
4. Have you ever been premedicated with antibiotics for you dental treatment?
5. Are you sensitive or allergic to any drugs or materials? __ Penicillin __ Tetracycline __ Metals
__Sulfa Drugs __ Aspirin __ Codeine __ Latex __ Other _____ Yes No
6. Do you have any disease, condition or problem not listed that you think we should know about?
Yes No If So, What? _____
7. Do you wear a cardiac pacemaker, or have you had heart surgery?Yes No
8. Do you smoke? If yes, how much? __ Cigarettes __ Cigars __ Packs per day.....Yes No
9. Do you have or have you had any of the following: (Please circle 'Y' for Yes or 'N' for No):

- | | | | |
|---------------------------|-----------------------|---------------------------|---------------------|
| Y N Herpes | Y N Diabetes | Y N Respiratory Disease | Y N Implant |
| Y N Headaches | Y N Emphysema | Y N Cold Sores | Y N Head Injuries |
| Y N Sinus Trouble | Y N Heart Ailments | Y N Drug Addiction | Y N Thyroid Disease |
| Y N Tuberculosis | Y N Joint Replacement | Y N Excessive Bleeding | Y N Asthma |
| Y N Psychiatric Treatment | Y N TMJ Disorder | Y N Hepatitis or Jaundice | Y N Stroke |
| Y N Radiation | Y N Venereal Disease | Y N AIDS Syndrome | Y N Seizures |

Dental History

1. Have you ever had any unfavorable reaction from a local anesthetic?.....Yes No
2. Have you had any serious trouble associated with any previous dental treatment.....Yes No
3. If so, explain? _____
4. How long since your last dental treatment? __Weeks __Months __Years
5. Does dental treatment make you nervous? __Slightly __Moderately __Extremely?Yes No
6. Would you desire to be pre-sedated?.....Yes No

Update – Since your last visit

1. Have you seen a medical doctor recently? Yes No
2. Have you had a change in your medication? Yes No
3. Have you had a change in your medical condition or had surgery? Yes No

Date: _____ Signature: _____

Update – Since your last visit

1. Have you seen a medical doctor recently? Yes No
2. Have you had a change in your medication? Yes No
3. Have you had a change in your medical condition or had surgery? Yes No

Date: _____ Signature: _____

I hereby grant authority to the dentist in charge of the care of the patient whose name appears in this Health History Form, to administer such anesthetics, analgesics, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of procedures, anesthetics/ drugs

Signature: _____ **Date:** _____ **Relationship to Patient:** _____