HEALTH HISTORY

Name: ___________________________________ **Birthdate**: ____________________________

Physician: _____________________________ **Phone number**: ______________________

Please indicate if you have (or have ever had) any of the following:

- ☐ Heart attack or heart disease
- ☐ High blood pressure
- ☐ Angina (chest pains)
- ☐ Artificial heart valve
- ☐ Bacterial endocarditis (SBE)
- ☐ Heart murmur
- ☐ Stroke
- ☐ Congestive heart failure
- ☐ Irregular heart beat
- ☐ Rheumatic heart disease
- ☐ Congenital heart disease
- ☐ Bleeding problem or blood disease
- ☐ Cancer treatment
- ☐ Diabetes
- ☐ Nervous system disease or seizures
- ☐ Thyroid disease
- ☐ Stomach or intestinal disease
- ☐ Kidney disease
- ☐ Hepatitis (A, B, C, or D)
- ☐ Other liver disease
- ☐ Arthritis
- ☐ Other muscle or joint disease
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Sinus problems
- ☐ Other respiratory condition
- ☐ Chemical substance addiction
- ☐ Osteoporosis therapy (Examples: Fosamax, Actonel, Boniva)
- ☐ Bisphosphonate therapy to reduce blood calcium (Examples: intravenous Aredia, Zometa)

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☐ **Yes** ☐ **No** Do you require an antibiotic prior to dental treatment?

☐ **Yes** ☐ **No** Do you take any blood thinners?

☐ **Yes** ☐ **No** Do you smoke or use tobacco products? Please specify: _________________________

Are you interested in quitting? ☐ Very interested ☐ Somewhat interested ☐ Not interested

☐ **Yes** ☐ **No** Are you a past user of tobacco products?

Allergic reactions to:

☐ Latex ☐ Local anesthetics ☐ Penicillin ☐ Aspirin
☐ Codeine ☐ Dental materials ☐ Metal ☐ Other ___________________

Immunosupressive conditions:

☐ Steroid therapy (e.g. prednisone) ☐ Radiation therapy ☐ Chemotherapy
☐ Lupus ☐ Rheumatoid arthritis ☐ HIV
☐ Organ transplant ☐ Spleen removed ☐ Other

Are you currently: ☐ Pregnant (Due date: __________) ☐ Nursing

Please indicate date of placement of any artificial joints :

	Hip	Knee	Ankle	Shoulder	Other
Right					
Left					

Do you have any of the following? Please specify.

□ Mental health condition? ____

____

□ Physical or mental disabilities that may require special care? ________________________________

____

□ Any disease, condition, or problem not listed here? ____

____

□ Have you ever been hospitalized or required surgery? ______________________________________

____

□ Do you have any undiagnosed symptoms? ____

____

Please list any prescription and over-the-counter medications and what they are taken for:

Medication	What is it taken for?

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature: ____ **Date:** ________________

Dates Reviewed:

DENTAL HISTORY

Name: ___________________________________ **Birthdate**: ____________________________

□ Yes □ No Do you have regular dental check-ups?
When was your last dental exam? _______________

□ Yes □ No Have you been happy with your previous dental treatment? If not, please explain:
____

□ Yes □ No Have you noticed any lumps or sores in your mouth?

□ Yes □ No Do your gums bleed when you brush your teeth?

□ Yes □ No Have you ever been treated for or told that you have periodontal (gum) disease?

□ Yes □ No Have you ever injured your face, jaws, or teeth?

□ Yes □ No Do you have any of the following: frequent headaches, ringing ears, neck or shoulder pain or stiffness, or jaw fatigue or achiness?

□ Yes □ No Do you wear any oral appliances or retainers?

□ Yes □ No Are you aware that you snore, or have you been told that you snore?

□ Yes □ No Have you been diagnosed with obstructive sleep apnea?

□ Yes □ No Is there anything about the appearance of your smile that you would like to change? Please explain: ____

Please circle the types of dental treatment you have experienced:

Orthodontics (braces)	Fillings	Crowns	Bridges
Periodontal (gum) treatment	Oral surgery	Implants	Dentures
Root canal treatment	TMJ Treatment	Bleaching	Veneers

Signature: ____ Date: ________________

PATIENT REGISTRATION

Date: ________________________________

Name: _______________________________

Preferred nickname: _____________________

Birthdate: ____________________________

Sex: Male ☐ Female ☐

Social security number: ________________

Marital Status: _________________________

Spouse's Name: _________________________

Address:

____

____

____

Phone Numbers:

Home: ______________________

Work: _______________________

Cell: ________________________

Email Address: ____

Patient Work Information

Employer: ____________________________

City, State: ___________________________

Position: ______________________________

How long held: _________________________

Spouse Work Information

Employer: _____________________________

City, State: ____________________________

Position: ______________________________

How long held: __________________________

Person responsible for payment:

Name: _______________________________

Relationship: ___________________________

Dental insurance:

Do you have dental insurance? ____________

Company name: _________________________

How did you hear about our office? ____

When available, by which method(s) would you prefer to be contacted for appointment reminders, etc.? Please check all that apply.

- ☐ Email
- ☐ Phone call (at ☐ home ☐ cell ☐ work)
- ☐ Text message
- ☐ Mail

☐ I authorize you to discuss my appointment times and treatment with:

___ my spouse

___ my parent(s)

___ my child(ren)

___ other ___________________________________

☐ I do not want my appointment times or treatment discussed with anyone.

Signature: ____ **Date:** _______________________

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for the payment for all dental services. This office will help prepare the patients' insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service fee of 1.5% per month (18% per annum) will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for dental care can only be extended for a period of six months from the date of patient examination, and treatment costs could vary from the estimate provided if additional treatment needs are discovered.

In consideration for the professional services rendered to me, or at my request, by the doctor, I agree to pay therefore the reasonable value of said services to the doctor, or her assignee, at the time services are rendered, or within five days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof.

I grant my permission to you, or your assignee, to telephone me at home, on my cell phone, or at my work to discuss matters related to this form.

____ ____________________

Signature Date