

# HEALTH HISTORY AND PATIENT INFORMATION

Who may we thank for referring you to our office? \_\_\_\_\_

## PERSONAL INFORMATION

Patient's Name \_\_\_\_\_ Nickname \_\_\_\_\_ Age \_\_\_\_\_  
Last First MI

Address \_\_\_\_\_  
Number and Street City State Zip

Telephone (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Occupation \_\_\_\_\_ SS# \_\_\_\_\_

Name of Spouse or Significant Other \_\_\_\_\_

Name of Emergency Contact \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

Name of your physician \_\_\_\_\_ Date last seen \_\_\_\_\_

Reason for coming to the dentist \_\_\_\_\_

## INSURANCE INFORMATION

Are you covered by a dental insurance plan? Yes \_\_\_\_\_ No \_\_\_\_\_

Name of insurance \_\_\_\_\_ Group / Policy # \_\_\_\_\_

Name of insurance policy holder \_\_\_\_\_ Social Security # \_\_\_\_\_

His/Her Date of birth \_\_\_\_\_ Have you received previous dental care under this plan? Yes \_\_\_\_\_ No \_\_\_\_\_

## HISTORY INFORMATION

YES NO

1. Have you ever required hospitalization for more than 24 hour?

2. Have you ever received general anesthesia?

3. Do you have any food or medication allergies?

If yes, what? \_\_\_\_\_

4. Are you currently taking any medication?

If yes, what? \_\_\_\_\_

5. Have you ever been seen by a dentist before?

If yes, when was your last visit? \_\_\_\_\_

Name of doctor \_\_\_\_\_

6. Have you ever received any form of fluoride?

7. Do you brush your teeth daily?

If yes, how many times? \_\_\_\_\_

8. Do you use toothpaste?

If yes, what kind? \_\_\_\_\_

9. Please provide the names and ages of your children \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you had any medical problems in the following areas? Please check all that apply.

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Blood                    | <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Muscles          |
| <input type="checkbox"/> Bones                    | <input type="checkbox"/> Heart            | <input type="checkbox"/> Nervous System   |
| <input type="checkbox"/> Endocrine                | <input type="checkbox"/> Kidney/bladder   | <input type="checkbox"/> Skin             |
| <input type="checkbox"/> Eyes, Ears, Nose, Throat | <input type="checkbox"/> Liver            | <input type="checkbox"/> Tonsils/Adenoids |

I have NOT had treatment for any of the above.

Has a physician ever diagnosed you with any of the following medical conditions? Please check all that apply.

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> ADD/ADHD             | <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Mental Retardation     |
| <input type="checkbox"/> Allergy              | <input type="checkbox"/> Emotional Disturbance      | <input type="checkbox"/> AIDS                   |
| <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Epilepsy                   | <input type="checkbox"/> HIV                    |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Eye Problems               | <input type="checkbox"/> Nutritional Deficiency |
| <input type="checkbox"/> Autism               | <input type="checkbox"/> Excessive Bleeding Problem | <input type="checkbox"/> Orthopedic Problems    |
| <input type="checkbox"/> Brain injury         | <input type="checkbox"/> Fainting                   | <input type="checkbox"/> Rheumatic Fever        |
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> Hearing Loss               | <input type="checkbox"/> Scoliosis              |
| <input type="checkbox"/> Cerebral Palsy       | <input type="checkbox"/> Heart Disease              | <input type="checkbox"/> Sickle Cell Anemia     |
| <input type="checkbox"/> Cleft lip/palate     | <input type="checkbox"/> Heart murmur               | <input type="checkbox"/> Spina Bifida           |
| <input type="checkbox"/> Convulsions/seizures | <input type="checkbox"/> Hemophilia                 | <input type="checkbox"/> Syndrome               |
| <input type="checkbox"/> Developmental Delay  | <input type="checkbox"/> Hepatitis                  | <input type="checkbox"/> Other                  |
|   | <input type="checkbox"/> Leukemia                   |   |

I have never been diagnosed as having any of the above conditions.

Is there anything else that you think we should know about you so that we may better meet your treatment needs?

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\_\_\_\_\_  
Signature of patient

\_\_\_\_\_  
Date

**Do Not Write below this line**

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**Medical History Summary**

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**SBE Recommendations**

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**Dental History Summary**

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\_\_\_\_\_  
Doctor's Signature

\_\_\_\_\_  
Date