

## New Patient & Health History Information

Although we primarily treat diseases of the mouth, we recognize the important interrelationship between the health of the mouth and the rest of the body. To assist us in better caring for you, please complete the following form to the best of your knowledge.

The information provided is important for us to deliver ideal and safe dental care to you.

Patient's Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_ Birth Date: \_\_\_/\_\_\_/\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

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

Are you under the care of a physician presently?  Yes  No

If yes, please explain for what? \_\_\_\_\_

Have you had surgery or been hospitalized in the past 5 years?  Yes  No

If yes, please explain for what? \_\_\_\_\_

Have you or a family member, had any unusual or serious reaction to anesthetics?  Yes  No

Has a physician recommended that you take antibiotics prior to dental treatment?  Yes  No

I would like fluoride alternatives provided at my exam and cleanings.  Yes  No

Do you wish to speak to the Doctor privately about anything?  Yes  No

Family History of Cancer, Diabetes, or Anesthesia Problems?  Yes  No

Do you often feel tired, fatigued or sleepy during daytime?  Yes  No

Do you wish you slept better or had more energy?  Yes  No

Have you ever been told you snore?  Yes  No

Has anyone ever observed you stop breathing during sleep?  Yes  No

Have you ever been prescribed a CPAP?  Yes  No

**Are you allergic to, or had a reaction with?**  ASPIRIN  ANESTHETICS  ACRYLIC  ANTIBIOTICS  CODEINE OR  
 NARCOTICS  SULFITES  OTHER MEDICATIONS

Do you have any serious allergies that are not listed? \_\_\_\_\_

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

	Yes	No		Yes	No		Yes	No
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Gastric Reflux	<input type="checkbox"/>	<input type="checkbox"/>	Nursing an Infant	<input type="checkbox"/>	<input type="checkbox"/>
Angina / Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis/osteopenia	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack/Failure	<input type="checkbox"/>	<input type="checkbox"/>	Osteonecrosis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy, <u>ANY</u> Chance	<input type="checkbox"/>	<input type="checkbox"/>
Birth Control	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	Heart malformation	<input type="checkbox"/>	<input type="checkbox"/>	Prosthetic Joint or Implant	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Retinopathy	<input type="checkbox"/>	<input type="checkbox"/>
Contact Lens	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	STDs	<input type="checkbox"/>	<input type="checkbox"/>
Contagious Diseases	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea / Snoring	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions / Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Immunocompromised	<input type="checkbox"/>	<input type="checkbox"/>	Smoking or Tobacco Use	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice / Yellowing	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Jaw Joint Pain / Clicking	<input type="checkbox"/>	<input type="checkbox"/>	Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>
Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	Swollen ankles / arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema / COPD	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Transplants	<input type="checkbox"/>	<input type="checkbox"/>
Eye Disease	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or Growths	<input type="checkbox"/>	<input type="checkbox"/>
Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Concerns	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>

**Please list any medications you are currently taking: (Medication, Dosage, Frequency)**

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**What is the pharmacy you would like relevant prescription medications sent?**

Store Name: \_\_\_\_\_ City: \_\_\_\_\_ Address: \_\_\_\_\_

## New Patient & Health History Information

### Primary Dental Insurance

Subscriber Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ Employer: \_\_\_\_\_

Subscriber ID: \_\_\_\_\_ Group: \_\_\_\_\_

### Secondary Dental Insurance

Subscriber Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ Employer: \_\_\_\_\_

Subscriber ID: \_\_\_\_\_ Group: \_\_\_\_\_

### Medical Insurance

Subscriber Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ Employer: \_\_\_\_\_

Subscriber ID: \_\_\_\_\_ Group: \_\_\_\_\_

Responsible Party Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I have made in completion of this form. I authorize my dentist, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers.

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Reviewed By