|  |  |
| --- | --- |
| **Personal Information (Please Print)** | Referred by |
|  |  |
| Patient Name (Last, First Middle) | Birth date | Age |
|  |  |  |
| Preferred Name / Nickname | Email address | Gender | 🌕 Male 🌕 Female |
|  |  |
| Address | City | State | Zip |
|  |  |  |  |
| Mark which number is best to contact you |
| 🌕 Cell Phone | 🌕 Home Phone | 🌕 Work Phone |
|  |  |  |
| Employer | Occupation |
|  |  |
| Social Security # | Driver’s License |
|  |  |
| Emergency Contact Person | Phone |
|  |  |
| Family Physician | Phone |
|  |  |
| **Dental Insurance Information** |
| Name of Insurance | ID or Social Security # |
|  |  |
| Name of Insured (Primary) | Birth date |
|  |  |
| Employer | Work Phone |
|  |  |
| **Responsible Party** |
| Person Responsible for Payment | Relationship |
|  |  |
| Address | City | State | Zip |
|  |  |  |  |
| Phone |
|  |
| **Health History** |
| Are you happy with your Smile | 🌕 Yes 🌕 No |
| If NOT, what would you change? |
|  |

|  |
| --- |
| **Mark appropriate answer (Leave BLANK if you do not understand the question)** |
| **Yes** | **No** |  |
| 🌕 | 🌕 | Is your general health good? |
| 🌕 | 🌕 | Has there been a change in your health within the last year? |
| 🌕 | 🌕 | Have you had problems with prior dental treatment? |
| 🌕 | 🌕 | Are you in pain now? |
| 🌕 | 🌕 | Have you been hospitalized or had a serious illness in the last three years? |
|  |  | Why |
|  |  |  |
| 🌕 | 🌕 | Are you being treated by a physician now? |
|  |  | For what? |
|  |  |  |

**Health History (Continue)**

|  |
| --- |
| **Have you experienced** |
| **Yes** | **No** |  |  | **Yes** | **No** |  |
| 🌕 | 🌕 | Chest pain (angina) |  | 🌕 | 🌕 | Dizziness |
| 🌕 | 🌕 | Swollen ankles |  | 🌕 | 🌕 | Ringing in ears |
| 🌕 | 🌕 | Shortness of breath |  | 🌕 | 🌕 | Headaches |
| 🌕 | 🌕 | Recent weight loss, fever, night sweats |  | 🌕 | 🌕 | Fainting spells |
| 🌕 | 🌕 | Persistent cough, coughing up blood |  | 🌕 | 🌕 | Blurred vision |
| 🌕 | 🌕 | Bleeding problems, bruising easily |  | 🌕 | 🌕 | Seizures |
| 🌕 | 🌕 | Sinus problems |  | 🌕 | 🌕 | Excessive thirst |
| 🌕 | 🌕 | Difficulty swallowing |  | 🌕 | 🌕 | Frequent urination |
| 🌕 | 🌕 | Joint paint, stiffness |  | 🌕 | 🌕 | Dry mouth |
| 🌕 | 🌕 | Frequent vomiting, nausea |  | 🌕 | 🌕 | Jaundice |
| **Do you have or have you had** |
| **Yes** | **No** |  |  | **Yes** | **No** |  |
| 🌕 | 🌕 | Heart disease |  | 🌕 | 🌕 | AIDS or HIV |
| 🌕 | 🌕 | Heart attack, heart defects |  | 🌕 | 🌕 | Tumors, cancer |
| 🌕 | 🌕 | Heart murmurs |  | 🌕 | 🌕 | Arthritis, rheumatism |
| 🌕 | 🌕 | Rheumatic fever |  | 🌕 | 🌕 | Eye disease |
| 🌕 | 🌕 | Stroke, hardening of arteries |  | 🌕 | 🌕 | Skin diseases |
| 🌕 | 🌕 | High blood pressure |  | 🌕 | 🌕 | Anemia |
| 🌕 | 🌕 | TB, emphysema, other lung diseases |  | 🌕 | 🌕 | VD (syphilis or gonorrhea) |
| 🌕 | 🌕 | Hepatitis, other liver disease |  | 🌕 | 🌕 | Herpes |
| 🌕 | 🌕 | Stomach problems, ulcers |  | 🌕 | 🌕 | Kidney, bladder disease |
| 🌕 | 🌕 | Allergies: to drugs, food medications |  | 🌕 | 🌕 | Thyroid, adrenal disease |
| 🌕 | 🌕 | Family history of diabetes, heart problems, tumors |  | 🌕 | 🌕 | Diabetes |
|  |  |  |  | 🌕 | 🌕 | Asthma |
| **Do you have or have you had** |
| **Yes** | **No** |  |  | **Yes** | **No** |  |
| 🌕 | 🌕 | Psychiatric care |  | 🌕 | 🌕 | Hospitalization |
| 🌕 | 🌕 | Radiation treatments |  | 🌕 | 🌕 | Blood transfusions |
| 🌕 | 🌕 | Chemotherapy |  | 🌕 | 🌕 | Surgeries |
| 🌕 | 🌕 | Prosthetic heart valve |  | 🌕 | 🌕 | Pacemaker |
| 🌕 | 🌕 | Artificial joint |  | 🌕 | 🌕 | Contact lenses |
| 🌕 | 🌕 | Mental handicap |  | 🌕 | 🌕 | Eating disorder |
| 🌕 | 🌕 | Organ transplant |  |  |  |  |
| **Are you taking** |
| **Yes** | **No** |  |  | **Yes** | **No** |  |
| 🌕 | 🌕 | Recreational Drugs |  | 🌕 | 🌕 | Tobacco in any form |
| 🌕 | 🌕 | Drugs, medicines, vitamins, supplements |  | 🌕 | 🌕 | Alcohol |
| Please list drugs |
|  |
| **Women ONLY** |
| **Yes** | **No** |  |  | **Yes** | **No** |  |
| 🌕 | 🌕 | Are you or could you be pregnant |  | 🌕 | 🌕 | Taking birth control pills |
| **All Patients** |
| **Yes** | **No** |  |
| 🌕 | 🌕 | Do you have or have had any other diseases or medical problems NOT Listed on this form? |
| If yes, Please list them |
|  |

To the best of my knowledge, I have answered every question completely and accurately. I will inform my Dentist of any change(s) in my health and/or medication.

|  |  |
| --- | --- |
| Patient / Guardian Signature | Date |
|  |  |
|  |  |