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MEDICAL HEALTH HISTORY

Patient's Name: _____ Birth Date: _____
Address: _____ City: _____ State ____ Zip _____
Marital Status: _____ Home Phone: _____
Place of Employment: _____ Business Phone: _____
Email: _____ Cell Phone: _____
Physician's Name: _____ Referred To Us By: _____
Dental Insurance Co. Name: _____
Most Convenient Day & Time For Your Dental Appointments: _____
Purpose of This First Dental Visit: _____

Person Financially Responsible For This Account: _____
Address: _____
Employment Name & Address: _____
Home Phone: _____
Social Security No.: _____

Emergency Contact _____ Phone _____

Is it okay to contact your Emergency Contact with your present medical condition? ____ Yes ____ No

Please check the best answer, and complete the blank lines where appropriate:

Has there been any change in your health in the last few years: any serious illness or operation? . . . ____ Yes ____ No
Have you been under medical treatment lately? . . . ____ Yes ____ No
Have you been hospitalized in the last five (5) years? . . . ____ Yes ____ No

Check, if you have had:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Lupus Erythematosus | <input type="checkbox"/> Emotional problems |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Transfusions | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Blood Pressure |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Drug reactions | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Allergies, Hives | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Fainting, Dizziness |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Swollen Ankles | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Immune Sys. Diseases |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Sick headaches | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Hepatitis (Type____) | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Cancer or tumors | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Radiation treatment | <input type="checkbox"/> Recent by-pass surgery | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pneumonia, lung or breathing problems |
| <input type="checkbox"/> Liver problems | <input type="checkbox"/> Heart valve replacements | <input type="checkbox"/> Mental problems | <input type="checkbox"/> Viral infections |
| <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Local anesthesia problems | <input type="checkbox"/> herpes, shingles, mononucleosis, |
| <input type="checkbox"/> Weight __gain__ loss | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Digestive problems | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Prosthetic joint replacements | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> __Hip__ __Knee__ __Etc. | <input type="checkbox"/> Cortisone medicines | |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Angina | |

Please list other conditions, diseases or problems not listed above _____

Please list any medication you are on now (including birth control pills) _____

Are you allergic to any medications, drugs, etc. such as a local anesthetic, penicillin, aspirin, codeine, other? . . . ____ Yes ____ No

Are you pregnant? If YES, what month are you in? _____ ____ Yes ____ No

How long since your last complete physical examination? _____

History of any family disease or illness? Yes No

Is there any reason to believe that you are in a high risk group for AIDS or other immune system illness? Yes No

If YES, Please explain: _____

Have you had a joint replacement - _____knee _____ hip _____ shoulder and/or _____ toe? Yes No

Have you had any injuries to your face or jaws? Yes No

Are any teeth sensitive to pressure, temperature, sweets? Yes No

Do you have any problems with _____swallowing, _____speaking _____chewing? Yes No

Do you smoke? Yes No

Are you conscious of bad breath or bad taste? Yes No

Do your gums bleed at times? Yes No

Do your teeth drift, move, or feel loose? Yes No

Do you understand the meaning of periodontal disease? Yes No

Have you ever had treatment for your gums? Yes No

Do you clench, grit, or grind your teeth? Yes No

Are you troubled with tension headaches, ear problems, aches in the joint muscles, clicking jaw? Yes No

Have you lost many teeth? If YES, why? _____ Yes No

Have you had complications following extractions? Yes No

Have you neglected having extracted teeth replaced? Yes No

Would you be interested in dental implants? Yes No

How often do you brush your teeth? _____ Floss your teeth _____

How long has it been since you have been to a dentist? _____

Do you desire to keep your natural teeth as long as possible? Yes No

Once your teeth and gums are in a healthy condition, do you desire to maintain your good dental health by regular preventive examinations and cleanings? Yes No

Are you dissatisfied with your dental appearance? Yes No

Do you snore or have you been told you snore? Yes No

Do you still have your tonsils? Yes No

Do you wake up often when you are sleeping? Yes No

Do you wake up from a night's sleep feeling refreshed or do you feel tired and groggy? Yes No

Do you fall asleep during the day when you don't want to? For ex.-driving the car, stopped in traffic, watching TV, reading or just sitting down? Yes No

Have you ever had a sleep study performed? Yes No

Do you currently have a CPAP machine? Do you use it every night? Yes No

Have you ever been diagnosed with a sleep disorder such as OSA(Obstructive Sleep Apnea) Yes No

Have you had troubles associated with previous dental experiences? If YES, please explain _____

Do you usually prefer a local anesthetic, such as Novocain? Yes No

Would you be interested in using analgesia, a "Happy Air" for improved comfort? Yes No

What are your greatest dental concerns at the present time? _____

Would you like your dental fees estimated in advance? Yes No

Is there any reason to believe that you are in a high risk group for AIDS or other immune system illness? Yes No

If YES, Please explain: _____

Are you interested in orthodontic treatment such as Invisalign (Clear Braces)? Yes No

On a scale from 1 to 10 (10 being the highest) - how would you rate your smile? 1 2 3 4 5 6 7 8 9 10
Would you like to learn about ways it could be improved. ____ Yes ____ No
Would you prefer a time-payment plan for extensive treatment procedures? ____ Yes ____ No
Would you like to make appointments on a pay-as-you-go basis? ____ Yes ____ No

Please feel free to fully discuss your dental, medical, and financial concerns with us

Patient's Signature: _____ *Date:* _____

Provider's Signature: _____

*Would you like your above signature to be placed on file for predeterminations
and other dental insurance benefits? ____ Yes ____ No*