Dental Health PC & Complete Dental Health LLC
Health History

(Confidential)

Please complete front and back of form

General Information

Today's Date:_____ E-mail Address:_____

Name: _____
Last First MI

Home Address: _____
Street/P.O. Box City State Zip

Home Phone: ( ) _____ Work Phone: ( ) _____ EXT_____ Employer _____

Cell Phone: ( ) _____ When and where are the best times to reach you? _____

Birth date: ___/___/___ Age:____ Whom may we thank for referring you? _____

SSN:_____ Physicians Name _____ Ph # _____

Drivers License #:_____ Emergency contact person _____ Ph# _____

Person Responsible for Account if other than yourself

Name: _____ Relation: _____ Home Phone: ( )_____ Work Phone: ( ) _____

Billing Address: _____
Street/P.O. Box City State Zip

Insurance Information: Yes No If yes please show your new card to a front office member.

Primary Insurance

Employer: _____ Insurance Co. Name: _____ Phone#: ( )_____ Group #:_____

Insured's Name: _____ ID /SSN: _____ Birthdate: ___/___/___ Relation: _____

Secondary Insurance

Employer: _____ Insurance Co. Name: _____ Phone#: ( )_____ Group #:_____

Insured's Name: _____ ID/SSN: _____ Birthdate: ___/___/___ Relation: _____

Dental History

Are you currently in pain? Yes No
If yes, where:_____

Have you experienced problems associated with any previous dental work? Yes No
If yes, explain:_____

Have you ever been told you have gum disease? Yes No

Do you require antibiotics before dental treatment? Yes No

Have you ever been treated for gum disease? Yes No

Have you had braces (orthodontics)? Yes No

Do you have any growth/swelling in your mouth? Yes No

Do you still have wisdom teeth? Yes No

Are your teeth sensitive to: Heat , Cold, Sweets, Pressure from biting or chewing Yes No
Where_____

Do you have frequent cold sores, canker sores, fever blisters on your gums, cheeks, lips? Yes No

Do you have or have you ever had any of the following?

Chronic neckaches/Headaches	Yes	No	Bleeding/sore gums	Yes	No	Unpleasant taste/bad breath	Yes	No
Tooth mobility or looseness	Yes	No	Food catching in your teeth	Yes	No	Jaw muscles tire, stiff, painful	Yes	No
Grinding/Clenching teeth	Yes	No	Pain or ringing in your ears	Yes	No	Clicking/Popping/Difficulty opening/closing jaw	Yes	No

Indicate which you use and how often:

Bristle Brush: Hard Medium Soft Water-Pik_____ Dental floss_____ Electric Brush: Type _____

OVER

Have there been any changes in your health in the past two years? Yes NO **If so, please list changes**

_____

List all prescribed and any over the counter medications

_____

_____

_____

Have you had or do you have any of the following medical conditions

Mitral valve prolapse/ Heart Murmur	Y	N	Fainting/ Dizziness	Y	N	Radiation Treatment for Cancer	Y	N	Anemia	Y	N
Angina /Chest Pain	Y	N	Kidney Disease	Y	N	Tumors	Y	N	Bleeding or Clotting Disorder	Y	N
Pacemaker	Y	N	Diabetes	Y	N	Arthritis	Y	N	Detached retina /Eye disorder	Y	N
Heart Surgery / Heart Attack	Y	N	Auto-Immune Disease	Y	N	Artificial Joints	Y	N	Gastro esophageal reflux disorder (G.E.R.D)	Y	N
Artificial Heart Valve	Y	N	HIV positive (AIDS)	Y	N	Chronic Cough	Y	N	Stomach Ulcers	Y	N
Congestive Heart Failure	Y	N	Thyroid Disease / Goiter	Y	N	Asthma	Y	N	Sleep Apnea (use of CPAP machine?)	Y	N
Shortness of Breath	Y	N	Seizures /Epilepsy	Y	N	Emphysema	Y	N	Are you taking or have you ever taken medication for osteoporopsis	Y	N
Rheumatic fever	Y	N	Liver disease Jaundice,	Y	N	Seasonal Allergies	Y	N			
Stroke	Y	N	Hepatitis Type____			Sinus/ Nasal problems	Y	N	Chemotherapy	Y	N
High Blood Pressure	Y	N	Tuberculosis	Y	N	MRSA	Y	N	Have you taken Zometa Aredia		
									Psychiatric treatment	Y	N

Are you allergic to any of the following

Penicillin	Yes	No	Local Anesthetic	Yes	No
Codeine	Yes	No	Sedatives	Yes	No
Sulfa	Yes	No	Aspirin	Yes	No
Latex	Yes	No	Ibuprofen	Yes	No
Iodine	Yes	No	Shellfish	Yes	No

Please List other allergies

_____

_____

_____

_____

_____

Chemical Dependency

Smoking Yes No
How much? _____ How long? _____

Chewing tobacco Yes No
How much? _____ How long? _____

History of alcohol or drug dependency
Yes No

Marijuana: None Medicinal Recreational

Women

Are you taking Birth Control? Yes No If **Yes** what type: Pills Shots Patch Norplant other: _____ Are you taking hormone replacements? (HRT) Y N

Are you pregnant or think you may be? _____ Due Date _____ Are you nursing? _____

With regards to oral contraceptives it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my family or me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand I am responsible for paying all services rendered at Dental Health PC or Complete Dental Health. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I am aware there are no service fees for 60 days. After that time the interest rate is at 18% annually with a minimum service fee of $5.00 per month for invoices.

Patient name (please Print)	Signature of Patient or Parent if Minor	Date