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PATIENT INFORMATION

PATIENT NAME & MIDDLE INITIAL (DR.MR. MRS.MISS. MS.) NICKNAME		SEX	AGE	BIRTH DATE
HOME PHONE #	CELL PHONE #			
ADDRESS				
CITY, STATE, ZIP	Have any family members or acquaintances been treated in our office before? If yes, please list:			
PATIENT EMPLOYER & PHONE #	PHYSICIAN	DENTIST		
PERSON TO CONTACT IN CASE OF EMERGENCY	EMERGENCY CONTACT PHONE #	REFERRED BY:		

INSURANCE INFORMATION

INSURED INFORMATION	DOB	RELATIONSHIP	
POLICY HOLDER	HOME PHONE #	CELL PHONE #	
INSURED ADDRESS	WORK PHONE #		
CITY, STATE, ZIP	SOCIAL SECURITY NUMBER		
MEDICAL INSURANCE	**POLICY HOLDER:**	**DOB:**	
NAME OF INSURANCE COMPANY	SUBSCRIBER ID NUMBER	PHONE #	
INSURANCE COMPANY ADDRESS	GROUP NAME NUMBER		
CITY, STATE, ZIP	SOCIAL SECURITY NUMBER		
DENTAL INSURANCE	**POLICY HOLDER:**	**DOB:**	
NAME OF INSURANCE COMPANY	GROUP NAME OR NUMBER	PHONE #	
INSURANCE COMPANY ADDRESS	SUBSCRIBER ID NUMBER		
CITY, STATE, ZIP	SOCIAL SECURITY NUMBER		

PLEASE REMEMBER THAT INSURANCE IS CONSIDERED A METHOD OF REIMBURSING THE PATIENT FOR FEES PAID TO THE DOCTOR AND IS NOT A SUBSTITUTE FOR PAYMENT. SOME COMPANIES PAY FIXED ALLOWANCES FOR CERTAIN PROCEDURES AND OTHERS PAY A PERCENTAGE OF THE CHARGE. IT IS YOUR RESPONSIBILITY TO PAY ANY DEDUCTIBLE AMOUNT, CO-INSURANCE, OR ANY OTHER BALANCE NOT PAID FOR BY YOUR INSURANCE COMPANY.

THIS SIGNATURE ON FILE IS MY AUTHORIZATION FOR THE RELEASE OF INFORMATION NECESSARY TO PROCESS MY CLAIM. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DOCTOR NAMED OF THE INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

SIGNED_____ DATE_____

HEALTH HISTORY

PLEASE ANSWER ALL QUESTIONS BY CIRCLING YES (Y) OR (N)
ALL RESPONSES ARE KEPT CONFIDENTIAL

1. Are you in good health?..... Y N

2. Has there been any change in your general health in the past year?..... Y N

3. Date of last physical exam?_____

4. Are you now under a physician's care for a particular problem?..... Y N

5. Have you had any serious illnesses, operations, or hospitalizations? If so,describe..... Y N
   _____

6. Have you had any adverse effects from dental treatment?..... Y N

7. Do you have or have you ever had?
   - A. Rheumatic fever or Rheumatic heart disease..... Y N
   - B. Congenital heart disease?..... Y N
   - C. Cardiovascular disease (heart trouble, heart attack, heart murmur, coronary artery disease, angina, high blood pressure, stroke, palpitations,heart surgery,pacemaker)? ..... Y N
   - D. Lung disease, (asthma, emphysema, chronic cough, bronchitis,pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)?..... Y N
   - E. Seizures, convulsions, epilepsy, fainting, psychiatric treatment, dizziness, nervous disorder, or breakdown?..... Y N
   - F. Bleeding disorder, anemia, bleeding tendency, blood transfusion; Do you bruise easily?..... Y N
   - G. Liver disease (jaundice, hepatitis)?..... Y N
   - H. Kidney disease?..... Y N
   - I. Diabetes?..... Y N
   - J. Thyroid disease (goiter)?..... Y N
   - K. Arthritis?..... Y N
   - L. Stomach ulcers or colitis?..... Y N
   - M. Glaucoma?..... Y N
   - N. Frequent or recurring mouth sores?..... Y N
   - O. Implants placed anywhere in your body (heart valve, hip, knee replacement)?..... Y N
   - P. Radiation (x-ray) treatment for cancer? ..... Y N
   - Q. Clicking or popping of jaw joint, pain near ear?..... Y N
   - R. Sinus or nasal problems?..... Y N
   - S. Any disease, drugs, or transplant operation that has depressed your immune system?..... Y N
   - T. Recurrent infections of any kind?..... Y N

8. Are you using or taking any of the following:
   - A. Inhaler?..... Y N
   - B. Thyroid medications?..... Y N
   - C. Antibiotics or sulfa drugs?..... Y N
   - D. Anticoagulants (Blood thinners)?..... Y N
   - E. High blood pressure medicine?..... Y N
   - F. Steroids (cortisone, etc.)?..... Y N
   - G. Tranquilizers (Valium, etc.)?..... Y N
   - H. Insulin, Diabenese, or similar drug?..... Y N
   - I. Digitalis, inderal, nitroglycerin, calcium channel blockers, Procardia or other heart medicine?..... Y N
   - J. Aspirin or ibuprofen (Motrin, Naprosyn, etc.)?..... Y N
   - K . Marijuana or other "street" drugs?..... Y N
   - L. Antihistamines or decongestants (Seldane)?..... Y N
   - M. Please list all medications you are currently taking.

     _____ ___mg _____per day
     _____ ___mg _____per day
     _____ ___mg _____per day
     _____ ___mg _____per day
     _____ ___mg _____per day

9. Are you allergic or had reaction to:
   - A. Local anesthetic (novocaine, etc.)?..... Y N
   - B. Penicillin, Amoxicillin, cephalosporins, or other antibiotics?..... Y N
   - C. Barbiturates, sedatives, etc?..... Y N
   - D. Aspirin or ibuprofen?..... Y N
   - E. Codeine or other pain killers?..... Y N
   - F. Latex or rubber products?..... Y N
   - G. Other allergies or reactions?..... Y N

     If yes, please list:_____
     _____

10. Do you smoke or chew tobacco?..... Y N

11. Do you use alcohol?..... Y N

12. Do you have any other disease, condition or problem not listed above that you think the doctor should know about?..... Y N

13. Do you wish to talk with the doctor privately about anything?..... Y N

14. FOR WOMEN ONLY

A. If you are using oral contraceptives, it is important that you understand that antibiotics and 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 medications is completed. Please consult your physician for further guidance.

B. If you are pregnant, possibly pregnant or trying to become pregnant, surgery, anesthetics, or any other medication may significantly harm your developing baby, especially during the first trimester. Please advise your doctor if there is any chance of your being pregnant!

C. Do you wish to have a pregnancy test?.....Y N

I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH HISTORY TO ASSIST THE DOCTOR IN PROVIDING THE BEST CARE POSSIBLE. I HAVE HAD THE OPPORTUNITY TO DISCUSS MY HEALTH HISTORY WITH MY DOCTOR.

_____ _____ _____
Signature of person completing health history | Date | Doctor's initials