Health History

Reason for today's visit ______________________________
Former Dentist ______________________________
Address ______________________________ Phone # (___) ______________________________

Date of last dental care ______________ Date of last dental X-rays ______________

Check yes if you have had problems with any of the following:

Yes	No		Yes	No		Yes	No	
❑	❑	Bad Breath	❑	❑	Grinding teeth	❑	❑	Sensitivity to hot
❑	❑	Bleeding Gums	❑	❑	Loose teeth or broken fillings	❑	❑	Sensitivity to sweets
❑	❑	Clicking or popping jaw	❑	❑	Periodontal treatment	❑	❑	Sensitivity when biting
❑	❑	Food collection between teeth	❑	❑	Sensitivity to cold	❑	❑	Sores or growths in mouth

Physician's Name ______________ Date of Last Visit ______________

Do you have any current health problems? ❑ Yes ❑ No If yes, please describe ______________

[Women] Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking birth control pills? ❑ Yes ❑ No

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

	Yes	No		Yes	No		Yes	No
AIDS	❑	❑	Excessive Bleeding	❑	❑	Kidney Disease	❑	❑
Anemia	❑	❑	Eye Problems	❑	❑	Liver Disease	❑	❑
Aneurysm	❑	❑	Facial Injuries	❑	❑	Latex Allergy	❑	❑
Arthritis	❑	❑	Fainting	❑	❑	Mitral Valve Prolapse	❑	❑
Artificial Heart Valve	❑	❑	Glaucoma	❑	❑	Nervous Disorders	❑	❑
Artificial Joints	❑	❑	Hay Fever/Allergies	❑	❑	Pacemaker	❑	❑
Asthma	❑	❑	Headaches	❑	❑	Psychiatric Care	❑	❑
Blood Disorder	❑	❑	Head Injuries	❑	❑	Radiation Treatment	❑	❑
Blood Transfusion	❑	❑	Heart Attack	❑	❑	Respiratory Disease	❑	❑
Cancer	❑	❑	Heart Bypass Surgery	❑	❑	Rheumatic Fever	❑	❑
Chemical Dependency	❑	❑	Heart Disease	❑	❑	Sinus Problems	❑	❑
Chemotherapy	❑	❑	Heart Murmur	❑	❑	Stroke	❑	❑
Circulatory Problems	❑	❑	Heart Problems	❑	❑	Thyroid Problems	❑	❑
Cosmetic Surgery	❑	❑	Hemophilia	❑	❑	Tobacco Habit	❑	❑
Diabetes	❑	❑	Hepatitis	❑	❑	Tuberculosis	❑	❑
Dry Mouth	❑	❑	High Blood Pressure	❑	❑	Ulcers	❑	❑
Epilepsy	❑	❑	HIV+	❑	❑	Venereal Disease	❑	❑

Are there any other medical or dental issues that the dentist should know about?

____

Please list medications you are currently taking:

____
____
____

Please list allergies:

____
____
____

AUTHORIZATION

I authorize my insurance company to pay the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. The undersigned hereby authorizes the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the doctor, and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the doctor. Any payments received by the doctor from my insurance coverage will be credited to my account or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance. I understand that where appropriate, credit reports may be obtained. I understand that I am financially responsible for all charges whether or not paid by insurance and that payments are due at the time of service.

Patient Signature (Parent/Guardian of child)______________________________ Date ______________