ENGLISH

Health History

Patient Name: ______________________________ ____________

Birth Date ____________

I. CIRCLE APPROPRIATE ANSWER (leave Blank if you do not understand question):

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
   Why? ____________
4. Yes No Are you being treated by a physician now? For what? ____________
   Date of last Medical Exam: ____________ Date of last Dental Appt.: ____________
5. Yes No Have you had problems with prior dental treatment?
6. Yes No Are you in pain now?

II. HAVE YOU EXPERIENCED:

7. Yes No Chest pain (angina)?
8. Yes No Swollen ankles?
9. Yes No Shortness of breath?
10. Yes No Recent weight loss, fever, night sweats?
11. Yes No Persistent cough, coughing up blood?
12. Yes No Bleeding problems, bruising easily?
13. Yes No Sinus problems?
14. Yes No Difficulty swallowing?
15. Yes No Diarrhea, constipation, blood in stools?
16. Yes No Frequent vomiting, nausea?
17. Yes No Difficulty urinating, blood in urine?
18. Yes No Dizziness?
19. Yes No Ringing in the ears?
20. Yes No Headaches?
21. Yes No Fainting spells?
22. Yes No Blurred vision?
23. Yes No Seizures?
24. Yes No Excessive thirst?
25. Yes No Frequent urination?
26. Yes No Dry mouth?
27. Yes No Jaundice?
28. Yes No Joint pain, stiffness?

III. DO YOU HAVE OR HAVE YOU HAD:

29. Yes No Heart disease?
30. Yes No Heart attack, heart defects?
31. Yes No Heart murmurs?
32. Yes No Rheumatic fever?
33. Yes No Stroke, hardening of arteries?
34. Yes No High blood pressure?
35. Yes No TB, emphysema, other lung diseases?
36. Yes No Hepatitis, other liver disease?
37. Yes No Stomach problems, ulcers?
38. Yes No Allergies to: drugs, foods, medications? Latex ?
39. Yes No Family history of diabetes, heart problems, tumors?
40. Yes No AIDS or ARC?
41. Yes No Tumors, cancer?
42. Yes No Arthritis, rheumatism?
43. Yes No Eye disease?
44. Yes No Skin diseases?
45. Yes No Anemia?
46. Yes No VD (syphilis or gonorrhea)?
47. Yes No Herpes?
48. Yes No Kidney, bladder disease?
49. Yes No Thyroid, adrenal disease?
50. Yes No Diabetes?

IV. DO YOU HAVE OR HAVE YOU HAD:

51. Yes No Psychiatric care?
52. Yes No Radiation treatments?
53. Yes No Chemotherapy?
54. Yes No Prosthetic heart valve?
55. Yes No Artificial joint?
56. Yes No Hospitalization?
57. Yes No Blood transfusions?
58. Yes No Surgeries?
59. Yes No Pacemaker?
60. Yes No Contact lenses?

V. ARE YOU TAKING:

61. Yes No Recreational drugs?
62. Yes No Drugs, medicines, (incl. Aspirin)?
   Please list: ____________
63. Yes No Tobacco in any form?
64. Yes No Alcohol?
65. Yes No Do you Drink Grapefruit Juice

VI. WOMEN ONLY:

65. Yes No Are you or could you be pregnant or nursing?
66. Yes No Taking birth control pills?

VII. ALL PATIENTS:

67. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?
   If so, please explain: ____________

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

Patient's signature ____________ Date ____________

RECALL REVIEW:

1. Patient's signature ____________ Date ____________
2. Patient's signature ____________ Date ____________
3. Patient's signature ____________ Date ____________

PATIENT INFORMATION

DATE ____________________

NAME ______________________________ ☐ MARRIED ☐ SINGLE ☐ MINOR ☐ MALE ☐ FEMALE
LAST FIRST M

ADDRESS ______________________________
STREET APT.# CITY STATE ZIP

BIRTH DATE ______________ TELEPHONE ______________
MONTH DAY YEAR HOME # WORK #

PLACE OF EMPLOYMENT ______________________________

IF FULL TIME STUDENT, SCHOOL NAME ______________ GRADE ______

DENTAL INSURANCE CO. ______________ SUBSCRIBER # ______ GROUP # ______

Has any member of your family ever been treated in our office? ☐ YES ☐ NO

Whom may we thank for referring you to our office? ______________________________

FAMILY INFORMATION

FILL IN BOTH SHADED BLOCKS FOR MINOR CHILD.
FILL IN APPROPRIATE SHADED BLOCK FOR ADULT.

FATHER (OR HUSBAND)	*MOTHER (OR WIFE)*
LAST FIRST M	LAST FIRST M
STREET CITY STATE ZIP	STREET CITY STATE ZIP
HOME TELEPHONE # WORK TELEPHONE #	HOME TELEPHONE # WORK TELEPHONE #
BIRTH DATE (MO/DAY/YEAR) SS#	BIRTH DATE (MO/DAY/YEAR) SS#
EMPLOYER	EMPLOYER
DENTAL INSURANCE CO. SUBSCRIBER# GROUP#	DENTAL INSURANCE CO. SUBSCRIBER# GROUP#

PERSON TO CONTACT IN CASE OF EMERGENCY

Outside of Immediate Family/Household

Name ______________________________

Address ______________________________

City/State/ZIP ______________________________

Telephone # ______________________________

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors ands/or other health professionals.

X ______________________________
☐ Adult Patient ☐ Father (Or Husband) ☐ Mother (Or Wife) ☐ Guardian

____
Date State Driver's License #

PERSON RESPONSIBLE FOR ACCOUNT

Please Check One
☐ Patient ☐ Father (Or Husband)
☐ Guardian ☐ Mother (Or Wife)

METHOD OF PAYMENT

Responsible party currently has an account with this office
☐ YES ☐ NO

☐ Payment in full at each appointment (cash or personal check)

☐ Payment in full at each appointment (☐ VISA ☐ MC)

______________ ______________

☐ I wish to discuss the Dental Office's Financial Policy

SERVICE CHARGE

If I do not pay the entire new balance within 25 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month (or a minimum charge of $3.00 for a balance under $200.00) which is an annual percentage rate of 18% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.