Patient Health History and Information

Patient Information

Last Name:	First Name:	Middle Name:	Preferred Name:
Home Phone:	Cell Phone:	Email Address:	
Mailing Address:	City:	State:	Zip:
Date of Birth:	Gender:	Social Security Number:	
Emergency Contact Name:	Phone Number:	Relationship to Patient:	

How did you hear about our office?_____

Insurance Information

Name of Insured:	Relationship to Patient:	Employer:
Date of Birth:	Social Security Number:	Insurance Company:
	Member ID:	Group Number:

Please mark an "X" in the box ONLY if this applies to you:

Is it hard to open your mouth?		Do you clench or grind your teeth?	
Does it hurt to chew, bite or swallow?		Does your jaw click, pop or hurt?	
Do your gums bleed when you brush or floss your teeth?		Do you have earaches or neck pain?	
Have you ever had periodontal (gum) treatments, like scaling and root planing (deep cleaning)		Does dental treatment make you nervous?	
Do you have, or have you ever had, any sores or growths in your mouth?		Have you ever experienced any sleep related breathing disorders?	

- Are you unhappy with your smile? Please explain, if yes:_____

_____

- Have you ever had a serious injury to your head or mouth? If yes, please describe what happened and when it happened:_____
- Have you ever had problems with dental treatment in the past? If yes, please describe what happened:_____
- Have you ever had a reaction to, or problem with, dental anesthesia? If yes, please describe what happened:_____

Medical History

- Have you had a **serious illness, operation or been hospitalized** in the past 10 years? If yes, please explain:_____

_____

- Have you had any type (either total or partial) of **joint replacement surgery** (such as for a hip, knee, shoulder, etc.)? If yes, please list surgeon, type and date of surgery:_____

_____

- Has a physician or previous dentist required you to take **antibiotics** before having any dental work done? If yes, what antibiotic was prescribed and how did you take it?_____

_____

- Have you had a **heart valve replacement or heart surgery**? If yes, please list surgeon and date of surgery:_____
- Have you had an **organ or bone marrow/stem cell transplant**? If yes, please list surgeon, type and date of surgery:_____
- Have you had, or currently have **cancer**? If yes, please list type, date of diagnosis and any chemotherapy or radiation treatments:_____
- Have you had a **blood transfusion**? If yes, when?_____
- Are you taking any **blood thinner** (such as Coumadin, Warfarin, rivarouxaban (Xarelto), dabigatran (Pradaxa), clopidogrel (Plavix), heparin or aspirin)? If yes, what medication are you taking:_____

_____

- Are you taking any medication to treat **osteoporosis** or Paget's disease (such as alendronate (Fosamax), risedronate (Actonel), ibandronate (Boniva), zolendronate (Reclast) and denosumab (Prolia)? If yes, what medication are you taking:_____
- Are you taking, or scheduled to take, **IV medication** to treat bone pain, hypercalcemia or skeletal complications resulting from Paget's Disease, multiple myeloma or metastatic cancer (such as denosumab (Xgeva), pamidronate (Aredia) or zolendronate (Zometa)? If yes, what medication are you taking and list your last dose and upcoming dose:_____

_____

- Are you taking **hormonal replacement**? If yes, what medication are you taking_____

_____

- Do you use any form of **tobacco or nicotine products** (cigarettes, cigars, snuff, chew, vapes)?_____
- Do you have a **chemical dependency** (including marijuana or other drugs)? If yes, what substance are you taking, how often, and was it prescribed by a doctor?_____
- **Please list any other prescription and/or over the counter medicines, vitamins, herbs and/or supplements**:_____

_____

_____

- Do you use **GLP-1 Glucagon-Like Peptide-1 medication**? If yes, what medication are you taking:

_____

- **Women Only**: Are you on **birth control**? If yes, what medication are you taking: _____
- Are you **pregnant**? If so, how many weeks?_____
- Are you **nursing**? If so, how many weeks?_____

Do you have, or have you been diagnosed with, any of the following conditions?

AIDS/HIV Infection	
Anemia	
Anxiety	
Arteriosclerosis	
Arthritis/Rheumatism	
Asthma (COPD)	
Autism	
Bronchitis	
Chronic Pain	
Congenital Heart Disease	
Congestive Heart Failure	
Coronary Artery Disease	
Damaged Heart Valves	
Depression	
Diabetes (Type I or Type II	

Low Blood Pressure	
Lupus	
Malnutrition	
Mental Health Disorder	
Neurological Disorder	
Osteoporosis	
Pacemaker/Implanted Defibrillator	
Post Traumatic Stress Disorder	
Previous Infective Endocarditis	
Rheumatic Heart Disease	
Sexually Transmitted Infection (STI)	
Sinus Trouble	
Stomach Ulcers	
Stroke	

Eating Disorder	
Emphysema	
Epilepsy	
Frequent Infection	
Gastrointestinal Disease	
GERD/Persistent Heartburn	
Glaucoma	
Headaches	
Heart Attack	
Heart Murmur/Rhythm Disorder	
Hemophilia	
Hepatitis, Jaundice or Liver Disease	
High Blood Pressure	
Immune Deficiency	
Kidney Problems	

Please list any drug allergies:_____

_____