Believe DENTAL CARE

Health History Form

Name: _____ S.S.N.: _____
Address: _____
City: _____ State: _____ Zip code: _____
Email: _____
Occupation: _____ Employer: _____
Name of Spouse: _____ S.S.N.: _____
Occupation: _____ Employer: _____

Home Phone: _____
Cell Phone: _____
Work Phone: _____
D.O.B.: _____
Spouse Work Phone: _____

Dental Insurance Company #1

Dental Insurance Name: _____ Phone: _____
Group #: _____ The dental insurance is provided through insured's name: _____
Insured's S.S.N.: _____ Insured's D.O.B.: _____ Insured's Employer: _____

Dental Insurance Company #2

Dental Insurance Name: _____ Phone: _____
Group #: _____ The dental insurance is provided through insured's name: _____
Insured's S.S.N.: _____ Insured's D.O.B.: _____ Insured's Employer: _____

In case of emergency, who should we contact other than spouse?

Name: _____ Relationship: _____ Phone: _____
Referred By: _____

For the following questions, circle yes or no, whichever applies . Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

1. Are you in good health ..... YES NO

2. Has there been any changes in your general health within the past year? ..... YES NO

3. My last physical exam was on: _____/_____/_____

4. Are you now under the care of a physician? ..... YES NO
If so, what is the condition being treated? _____

5. The name and address of your physician(s) is:. _____ Phone: _____

6. Have you had any serious illness, operation, or been hospitalized in the past 5 years? ..... YES NO
If so, what is the condition being treated? _____

7. Are you taking any medicine(s) including non-prescription Medicine? ..... YES NO
If so, what medicine(s) are you taking? _____

8. Do you have or have you had any of the following diseases?

a. Damaged heart valves or artificial heart valves, including heart murmur, rheumatic heart disease, rheumatic fever, or mitral valve prolapse? YES NO
b. Cardiovascular disease (heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)..... YES NO
1. Do you have chest pain upon exertion? ..... YES NO
2. Are you ever short of breath after mild exercise or when laying down? ..... YES NO
3. Do your ankles swell? ..... YES NO
4. Do you have a cardiac pacemaker? ..... YES NO
c. Allergy ..... YES NO
d. Sinus trouble ..... YES NO
e. Asthma or hay fever ..... YES NO
f. Fainting spells or seizures ..... YES NO
g. Diabetes ..... YES NO
h. Hepatitis, jaundice or liver disease ..... YES NO
i. AIDS or HIV infection ..... YES NO
j. Thyroid problems ..... YES NO
k. Respiratory problems, emphysema, bronchitis, etc ..... YES NO
l. Arthritis, painful swollen joints, or prosthetic joint replacement ..... YES NO
m. Stomach ulcer or hyperacidity ..... YES NO

n. Kidney problems or renal dialysis ..... YES ◯ NO ◯
o. Tuberculosis ..... YES ◯ NO ◯
p. Persistent cough or cough that produces blood ..... YES ◯ NO ◯
q. Persistent swollen glands in neck ..... YES ◯ NO ◯
r. Low blood pressure ..... YES ◯ NO ◯
s. Sexually transmitted disease ..... YES ◯ NO ◯
t. Epilepsy or other neurological disease ..... YES ◯ NO ◯
u. Problems with mental health ..... YES ◯ NO ◯
v. Cancer ..... YES ◯ NO ◯

9. Have you had any abnormal bleeding? ..... YES ◯ NO ◯

a. have you ever required a blood transfusion ..... YES ◯ NO ◯

10. Do you have any blood disorders such as anemia? ..... YES ◯ NO ◯

11. Have you ever had any treatment for a tumor or a growth? ..... YES ◯ NO ◯

12. Are you allergic or have you had a reaction to:

a. Local anesthetics ..... YES ◯ NO ◯
b. Penicillin or other antibiotics ..... YES ◯ NO ◯
c. Barbiturates, sedatives, or sleeping pills ..... YES ◯ NO ◯
d. Aspirin ..... YES ◯ NO ◯
e. Codeine or other narcotics ..... YES ◯ NO ◯
f. Other ..... YES ◯ NO ◯

13. Have you had any serious trouble associated with previous dental treatment? ..... YES ◯ NO ◯
if so please explain: _____

14. Do you have any disease, condition, or problem NOT listed above that you we should know about? ..... YES ◯ NO ◯
if so please explain: _____

15. Are you wearing contact lenses? ..... YES ◯ NO ◯

16. Are you wearing removable dental appliances? ..... YES ◯ NO ◯

17. Do you smoke or use any other tobacco products? ..... YES ◯ NO ◯

Women:

18. Are you pregnant? ..... YES ◯ NO ◯

19. Are you nursing? ..... YES ◯ NO ◯

20. Are you taking birth control? ..... YES ◯ NO ◯

FOR OFFICE USE ONLY - PLEASE DO NOT FILL OUT

Dental History:

1. Chief dental complaint: _____
2. How long has it been since you last visited a dental office? _____ Last x-rays? _____
3. What was done at that time? _____
4. Why did you leave your last dentist? _____
5. Do any of your teeth ache, or are any sensitive to heat, cold or pressure? _____
6. Do you grind your teeth or clench your jaw? _____
7. Do you have frequent headaches? _____
8. Are you aware of any sores or growth in your mouth? _____
9. Have you ever had any complications during or following dental treatment? _____
10. How important are your natural teeth to you? Not Important 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ Important
11. How do you feel about your smile? Not Important 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ Important
12. Are your teeth white enough? ..... YES ◯ NO ◯
13. Are you concerned about bad breath? ..... YES ◯ NO ◯
14. Do you snore or have you been diagnosed with sleep apnea? ..... YES ◯ NO ◯

I certify that I have read and understand the above. I have acknowledge that my question, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my, dentist or any member of his/her staff, responsible for errors or omissions that I have made in completion of this from.

Signature of Patient: _____ Date: _____

Signature of Doctor: _____ Witness: _____