Patient Health History

We appreciate the confidence you place in us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. In order that we may provide you with the best possible dental services, please answer all of the questions completely and accurately as incorrect information may compromise your treatment. The Health History will become a part of your dental treatment record and is considered "Confidential."

Date_____

Patient Information:

Name Last:_____First:_____Middle:_____Sex:_____
Date of Birth:_____Social Security #:_____Marital Status:_____
Address:_____City:_____State:_____Zip:_____
Phone Home:_____Cell:_____Work:_____
Email:_____Referred by:_____
Emergency Contact Name:_____Relationship:_____Phone:_____

Responsible Party Information(if patient is a minor or are covered under parents insurance but over 18 and parent/guardian is financially responsible):

Name:_____Relationship:_____Date of Birth:_____
Address:_____City:_____State:_____Zip:_____
Phone Home:_____Cell:_____Social Security #:_____

Dental History

Have you ever had any complications with dental treatment? ☐Yes ☐No

If yes, please explain_____

	Yes	No
Are you apprehensive about dental treatment?	☐	☐
Do you gag easily?	☐	☐
Do you wear dentures?	☐	☐
Do your gums bleed easily	☐	☐
Have you ever been told you have infected gums or periodontal disease?	☐	☐
Do you get sores in your mouth often?	☐	☐
Are your teeth sensitive to hot and cold?	☐	☐
Are you dissatisfied with the appearance of your teeth?	☐	☐
Does your jaw bother you?	☐	☐
Do you notice you clench or grind your teeth?	☐	☐

How often do you brush? _____ How often do you floss? _____

Have you ever had complications to dental anesthetic?	☐	☐

Medical Health

Name and phone number of physician _____

Please answer Yes or No if you have or ever had any of the following:

	Yes	No		Yes	No
Heart Problems?.....	☐	☐	Diabetes……..	☐	☐
Chest pain……..……..	☐	☐	Do you smoke.....	☐	☐
Shortness of breath…….……	☐	☐	Use smokeless tobacco……	☐	☐
Blood pressure problems…….…….....	☐	☐	History of alcohol/drug abuse……...	☐	☐
Heart murmur……	☐	☐	Herpes or other STD……..	☐	☐
Heart valve problem…….....|	☐	☐	HIV-positive/AIDS……	☐	☐
Heart attack……..	☐	☐	Hepatitis, jaundice or liver trouble……	☐	☐
Pacemaker……..	☐	☐	Asthma……	☐	☐
Artificial heart valve……...	☐	☐	Kidney Disease……..	☐	☐
Rheumatic fever……..	☐	☐	Liver Disease……..	☐	☐
Bone or Joint problems……...	☐	☐	Mental Health Care……	☐	☐
Arthritis……..	☐	☐	Anxiety Disorder……	☐	☐
Back or neck pain……..	☐	☐	Tuberculosis……..	☐	☐
Joint replacement……	☐	☐	Sinus problems……..	☐	☐
If yes, do you need to be pre-medicated for dental appointments?.....	☐	☐	Glaucoma……	☐	☐
			Women		
Fainting Spells, Seizures, or Epilepsy…	☐	☐	Are you taking contraceptives/hormones.	☐	☐
Stroke(s)……..	☐	☐	Are you pregnant……..	☐	☐
Frequent or severe headaches……	☐	☐	Are you nursing……	☐	☐
Thyroid problems……	☐	☐	Have you reached menopause……	☐	☐
Cancer/Tumor……	☐	☐			

Allergies

Are you allergic, or have you reacted adversely to any of the following?

	Yes	No		Yes	No
Local anesthetics……	☐	☐	Latex……..	☐	☐
Penicillin or other antibiotics……..	☐	☐	Codeine, Demerol, or other narcotics…	☐	☐
Sulfa drugs……..	☐	☐	Barbiturates, sedatives, or sleeping pills	☐	☐

Please list any other allergies_____

Medications

List all Medications you are presently taking including herbal medications, vitamins, etc.

Surgeries:

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform Dr. Laws and/or the hygienist at the next appointment without fail.

Signature Date: