Let Your Smile Change the World.

WELCOME TO OUR OFFICE! Our goal is to make every visit pleasant and educational. We strive to teach good oral care that will enable you to have a beautiful smile that lasts a lifetime!

PATIENT HEALTH HISTORY FORM

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

PATIENT INFORMATION

PATIENT FIRST NAME:	PATIENT LAST NAME:	PREFERS TO BE CALLED:	
BIRTH DATE: SEX: M F	SCHOOL/EMPLOYER:	GRADE:	
OTHER FAMILY MEMBERS TREATED HERE:		HOBBIES:	
CELL PHONE / CARRIER:	HOME PHONE:	EMAIL:	
ADDRESS:	CITY:	STATE:	ZIP:

RESPONSIBLE PARTY* INFORMATION *For patients under 18, this form must be completed and signed by a legally responsible guardian.

☐ Check if patient is the responsible party – list all people who should have access to patient information

FIRST NAME:	LAST NAME:	RELATIONSHIP TO PATIENT:	
BIRTH DATE: SEX: M F	EMAIL:		
CELL PHONE / CARRIER:	HOME PHONE:		
ADDRESS:	CITY:	STATE:	ZIP:

FIRST NAME:	LAST NAME:	RELATIONSHIP TO PATIENT:	
BIRTH DATE: SEX: M F	EMAIL:		
CELL PHONE /CARRIER:	HOME PHONE:		
ADDRESS:	CITY:	STATE:	ZIP:

INSURANCE INFORMATION (please provide your Insurance Card and I.D. so we can keep a copy on file)

PRIMARY POLICY HOLDER'S NAME (as it appears on the card):		
POLICY HOLDER'S DATE OF BIRTH:	SSN:	EMPLOYER:
DENTAL INSURANCE COMPANY NAME:		
POLICY ID NUMBER:	POLICY GROUP NUMBER:	

PRIMARY POLICY HOLDER'S NAME (as it appears on the card):		
POLICY HOLDER'S DATE OF BIRTH:	SSN:	EMPLOYER:
DENTAL INSURANCE COMPANY NAME:		
POLICY ID NUMBER:	POLICY GROUP NUMBER:	

DENTAL / MEDICAL INFORMATION

DENTIST:	DATE LAST SEEN:	REASON:
PHYSICIAN:	DATE LAST SEEN:	REASON:
WHAT IS YOUR PRIMARY CONCERN / WHY ARE YOU HERE? :		
WHY DID YOU SELECT OUR OFFICE? :		
HOW OFTEN DOES THE PATIENT BRUSH THEIR TEETH? :		FLOSS? :
PLEASE LIST ANY CURRENT MEDICATIONS:		

FOR THE FOLLOWING QUESTIONS, PLEASE CIRCLE YES OR NO. THE ANSWERES ARE FOR OUR OFFICE RECORDS ONLY AND WILL BE CONSIDERED CONFIDENTIAL. A THOROUGH AND COMPLETE HISTORY IS VITAL FOR A PROPER DENTAL OR ORTHODONTIC EVALUATION.

PATIENT PROFILE

DOES THE PATIENT:

FOLLOW DIRECTIONS WELL?	Y	N	HAVE DENTAL ANXIETY?	Y	N
HAVE ANY LEARNING DISABILITIES?	Y	N	REQUIRE MEDICATION BEFORE APPOINTMENTS?	Y	N
FEEL SELF CONSCIOUS ABOUT THEIR TEETH?	Y	N			

MEDICAL HISTORY

NOW OR IN THE PAST, HAS THE PATIENT HAD:

KIDNEY PROBLEMS?	Y	N	CONGENITAL HEART DEFECT?	Y	N
DIABETES?	Y	N	HEART MURMUR?	Y	N
CANCER OR TUMORS?	Y	N	EYE, EAR, NOSE OR THROAT CONDITIONS?	Y	N
POLIO, LUPUS, MONO, TB OR PNEUMONIA?	Y	N	HAYFEVER, ASTHMA, SINUS TROUBLE OR HIVES?	Y	N
PROBLEMS OF THE IMMUNE SYSTEM?	Y	N	TONSIL OR ADENOID CONDITIONS?	Y	N
AIDS OR HIV POSITIVE?	Y	N	ANY IMPLANTS OR TRANSPLANTS?	Y	N
HEPATITIS, JAUNDICE OR LIVER PROBLEMS?	Y	N	ARTIFICIAL BONES/JOINTS/VALVES?	Y	N
FAINTING SPELLS, SEIZURES OR EPILEPSY?	Y	N	IS THE PATIENT PREGNANT?	Y	N
VISION, HEARING, OR TASTE DIFFICULTIES?	Y	N	A SUBSTANCE ABUSE PROBLEM?	Y	N
ABNORMAL BLEEDING, BRUISING OR ANEMIA?	Y	N	CHEWED OR SMOKED TOBACCO?	Y	N
HIGH OR LOW BLOOD PRESSURE?	Y	N	ANY HOSPITALIZATIONS?	Y	N
CHEST PAIN, SHORTNESS OF BREATH?	Y	N	ANY OPERATIONS?	Y	N

PLEASE LIST ANY OTHER PHYSICAL PROBLEMS OR SYMPTOMS:_____

ALLERGIES OR REACTIONS TO ANY OF THE FOLLOWING:

LOCAL ANESTHETIC?	Y	N	SULFA MEDICATIONS?	Y	N
ASPIRIN?	Y	N	CODEINE OR OTHER NARCOTICS?	Y	N
IBUPROFEN?	Y	N	METALS (JEWELRY, CLOTHING SNAPS)?	Y	N
PENICILLIN?	Y	N	LATEX (GLOVES, BALLOONS)?	Y	N

PLEASE LIST ANY OTHER KNOWN ALLERGIES:_____

DENTAL HISTORY

NOW OR IN THE PAST, HAS THE PATIENT HAD:

INJURIES TO THE FACE, MOUTH OR CHIN?	Y	N	SPEECH IMPEDIMENT OR DIFFICULTIES?	Y	N
PERMANENT TEETH EXTRACTED?	Y	N	MOUTH BREATHING OR SNORING?	Y	N
SUPERNUMERARY (EXTRA) TEETH?	Y	N	TOOTH GRINDING?	Y	N
CONGENITALLY MISSING TEETH?	Y	N	JAW CLENCHING, CLICKING OR LOCKING?	Y	N
CHIPPED OR INJURED TEETH?	Y	N	PAIN IN JAW OR RINGING IN THE EARS?	Y	N
SENSITIVITY TO HOT/COLD; TEETH TRHOB/ACHE?	Y	N	DIFFICULTY CHEWING OR OPENING JAW?	Y	N
JAW FRACTURE, CYST OR MOUTH INFECTION?	Y	N	LOOSE, BROKEN OR MISSING FILLINGS?	Y	N
ROOT CANALS TREATED?	Y	N	TEETH IRRITATING CHEEK, LIP TONGUE OR PALATE?	Y	N
BLEEDING GUMS, BAD TASTE OR MOUTH ODOR?	Y	N	FREQUENT CANKER OR COLD SORES?	Y	N
PERIODONTAL "GUM PROBLEMS"?	Y	N	TAKING ANY FORM OF FLUORIDE?	Y	N
THUMB SUCKING HABIT? UNTIL WHAT AGE?_____	Y	N	SERIOUS PROBLEMS W/PREVIOUS DENTAL WORK?	Y	N
TONGUE THRUSTING HABIT?	Y	N	EVER HAD ORTHODONTIC CARE?	Y	N

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes to the patient's medical/dental status. I also understand that for training purposes only, this office may occasionally film their office and clinical procedures. I authorize the dental staff to perform the necessary dental services the patient may need.

SIGNATURE OF PARENT / GUARDIAN / PATIENT (IF OVER 18) **DATE**

I have received a copy of the Notice of Privacy Practice for the practice.

SIGNATURE OF PARENT / GUARDIAN / PATIENT (IF OVER 18) **DATE**

--OFFICE USE ONLY--

I verbally reviewed the medical/dental information on this form with the patient and/or guardian named herein.
Patient's Chief Concern: Initial: _____Date: _____