Health History Form

Date ________________

Name__________________________ Home Phone (____)___________ Cell (____)____________ Work (____)___________

Address____________________________ City ______________________________ State __________ Zip Code________

Date of Birth _______________ Sex ☐ M ☐ F Email _________________________ Occupation ____________________

SS#__________________ Emergency Contact___________________ Relationship_____________ Phone (____)____________

If you are completing this form for another person, what is your relationship to this person? ___________________________________

Whom can we thank for your referral to this office? ____

INSURANCE INFORMATION

INSURED PERSON'S FULL NAME — INSURED PERSON D.O.B

SOCIAL SECURITY NUMBER — RELATIONSHIP TO PATIENT — WORK PHONE

INSURANCE COMPANY NAME — GROUP OR LOCAL NUMBER

If you have secondary insurance, please complete the following:

INSURED PERSON'S FULL NAME — INSURED PERSON D.O.B

SOCIAL SECURITY NUMBER — RELATIONSHIP TO PATIENT — WORK PHONE

INSURANCE COMPANY NAME — GROUP OR LOCAL NUMBER

EMPLOYER NAME — FULL ADDRESS OF EMPLOYER

I authorize insurance payment directly to Dr. Peter R. Brown. I understand that I am ultimately responsible for all charges whether paid by my insurance or not. I authorize Dr. Peter R. Brown to release information required to secure the benefits.

Signature of Responsible Party: ____

PAYMENT OPTIONS AVAILABLE: Check • Cash • Visa • Discover • Care Credit

Payment in full is expected at each appointment unless prior arrangements have been made.
Late Charges: I understand that any balance over 60 days will incur a fee of 1.5% monthly on the owed balance. In case of default on this account, I agree to pay collection costs and reasonable attorney fees resulting in the attempt to collect on the owed amount.

Signature of Responsible Party: ____

DENTAL INFORMATION **Signature of Responsible Party:**

YES	NO	DON'T KNOW		YES	NO	DON'T KNOW	
☐	☐	☐	Do your gums bleed when you brush?	☐	☐	☐	Have you ever had orthodontic treatment?
☐	☐	☐	Are your teeth sensitive to cold, hot, sweets, or pressure?	☐	☐	☐	Do you have headaches, earaches or neck pains?
☐	☐	☐	Have you had any periodontal (gum) treatments?	☐	☐	☐	Do you wear removable dental appliances?

☐ ☐ ☐ Have you had any serious/difficult problem associated with any previous dental treatment? If so, explain_______________________

How would you describe your current dental problem?____________________________________ Family history of Periodontal Disease _______

Date of your last dental exam_____________ Date of last hygiene appt ___________Name of last dentist_________________________________

What was done at that time? ____Date of last dental x-rays_________________

How do you feel about the appearance of your teeth?____________________________ Do you have any problems with bad breath?_______________

MEDICAL INFORMATION

YES	NO	DON'T KNOW	
☐	☐	☐	Are you in good health?
☐	☐	☐	Has there been any changes in your health within the past year?
☐	☐	☐	Are you under the care of a physician? If so, what are the conditions being treated?______________________

____Date of last exam____________

Physician(s)____
Name — Phone — Address — City/State/Zip

☐ ☐ ☐ Have you ever had any serious illness, operation, or been hospitalized in the past five years? If so, what was the illness or problem?____

☐ ☐ ☐ Do you drink soft drinks / sports drinks? If yes how many per day? __________________

☐ ☐ ☐ Do you drink alcoholic beverages? If yes, how much alcohol did you drink in the past week?_______month?_________

☐ ☐ ☐ Are you alcohol and/or drug dependent? If so have you received treatment? (check one) ☐ YES ☐ NO

☐ ☐ ☐ Do you use tobacco (smoking or chew)? If so, how interested are you in quitting? ☐ Very ☐ Somewhat ☐ Not at all
How many years have or did you use tobacco? _________ How much tobacco did you use per day? _________________________

☐ ☐ ☐ Have you taken steroids during the past two years? ☐ YES ☐ NO

Are you taking any medications (Prescription or Over-the-Counter) ? If yes, for what purposes? PLEASE LIST BELOW

NAME OF DRUG	PURPOSE	DATE

Are you allergic to or have you had a reaction to?	YES	NO	DON'T KNOW
Local Anesthetics	☐	☐	☐
Penicillin or other antibitoics	☐	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐	☐
Sulfa Drugs	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Latex	☐	☐	☐
Iodine	☐	☐	☐
Hay fever/seasonal	☐	☐	☐
Kiwi, Strawberries, Bananas	☐	☐	☐
Other (specify)_________________________			

Please (x) a response to indicate if you have or have had any of the following diseases or problems

	YES	NO	DON'T KNOW
Abnormal Bleeding	☐	☐	☐
ADD and/or ADHD	☐☐☐	☐	☐
AIDS or HIV	☐	☐	☐
Anemia	☐	☐	☐
Arthritis	☐	☐	☐
Asthma	☐	☐	☐
Blood transfusion *If yes, date*__________	☐	☐	☐
Cancer/Chemotherapy/Radiation			
_____Bisphosphonate Treatment	☐	☐	☐
Cardiovascular diseases? *If yes, please specify*	☐	☐	☐
_____Angina Pectoris			
_____ Heart murmur			
_____Bypass Surgery			
_____Mitral Valve Prolapse			
_____Pacemaker			
_____Rheumatic fever			
_____Artificial valves			
_____Heart attack *Date* _________			
Chest Pain upon exertion			
Chronic Pain	☐	☐	☐
Disease, drug, or radiation-induced immunosuppression	☐	☐	☐
Diabetes. *If yes, please specify*			
_____Type 1 (insulin dependent) _______ Type II			
Dry Mouth		☐	☐
Eating disorder. *If yes, please specify*____________	☐	☐	☐ ☐
Epilepsy	☐	☐	☐
Fainting Spell or Seizures	☐	☐	☐
Gastrointestinal Disease	☐	☐	☐
G.E. Reflux/Persistent Heartburn	☐	☐	☐
Glaucoma	☐	☐	☐

☐ ☐ ☐ ☐ ☐ ☐

	YES	NO	DON'T KNOW
Hemophilia	☐	☐	☐
Hepatitis, Jaundice, or Liver Disease	☐	☐	☐
High/Low Blood Pressure (circle one)	☐	☐	☐
Recurrent Infection			
*If yes, indicate type of infection*_______	☐	☐	☐
Mental Health Disorder	☐		
Menopausal	☐	☐	☐
Neurological Disorders			
Osteoporosis			
_____Oral/I.V. Bisphosphonate Treatment	☐	☐	☐
Persistant swollen glands	☐	☐	☐
Respiratory problems. If yes, please specify:			
___Emphysema ___Bronchitis, etc.	☐	☐	☐
Severe headaches/migraines	☐	☐	☐
Sexually transmitted Disease	☐	☐	☐
Sinus Trouble	☐	☐	☐
Sores or ulcers in the mouth	☐	☐	☐
Stroke. *If yes, date*_________			
Lupus	☐	☐	☐
Tuberculosis	☐	☐	☐
Thyroid problems	☐	☐	☐
Joint Replacement		☐	☐
Do you have any disease not listed above that you think we should know about? *Please explain* _______________			
Have you ever been told you needed to premedicate before your dental appointment?	☐	☐	
Are you on Blood Thinners? ___ Plavix ___ Coumadin ___ Aspirin			
Are you pregnant and/or nursing?	☐	☐	☐

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any other member of his/her staff responsible for any action they take because of errors or ommission that I may have made in the completion of this form.

____

SIGNATURE OF PATIENT/LEGAL GUARDIAN DATE

Date	Comments/Changes	Signature of patient	Signature of Dentist
_________	______________________	______________________	______________________
_________	______________________	______________________	______________________
_________	______________________	______________________	______________________
_________	______________________	______________________	______________________
_________	______________________	______________________	______________________