Health History

PATIENTS NAME_____ **AGE**_____

SEX M/F **HEIGHT** FT___IN___ **WEIGHT** LBS_____ **DATE OF BIRTH**_____/_____/_____

INSTRUCTION: Answer all questions and fill in the blank spaces when indicated. Answers to the following questions are for our records only and will be kept confidential. The information you provide to us is used to assure maintenance of your overall well being.

Why are you here today?_____

When was your last visit to a dental office?_____/_____/_____

	YES	NO
1. Are you in good health	_____	_____
2. Has there been any changes in your general health within the past year	_____	_____
3. My last physical was on _____		
4. Are you now under the care of a physician	_____	_____
A. If so, what is the condition being treated _____		
5. The name and address of my physician is _____		
_____		
6. Have you had any serious illness or operation	_____	_____
A. If so, what was the illness or operation _____		
7. Have you been hospitalized or had a serious illness within the past five	_____	_____
A. if so, what was the problem _____		
8. Do you have or have you had any of the following diseases or problems:		
A. Damage heart valves or artificial heart valves	_____	_____
B. Congenital heart lesion or murmurs	_____	_____
C. Cardiovascular disease:		
1) Heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke	_____	_____
2) Do you have a cardiac pacemaker	_____	_____
D. Sinus trouble	_____	_____
E. Asthma	_____	_____
F. Allergy	_____	_____
G. Hives or skin rash	_____	_____
H. Fainting spells or seizures	_____	_____
I. Diabetes	_____	_____
J. Hepatitis, jaundice or liver disease	_____	_____
K. Arthritis	_____	_____
L. Inflammatory rheumatism (painful, swollen joints)	_____	_____

PATIENT INFORMATION Date:_____

LastName:_____ FirstName:_____M.I._____

Home address:_____City:_____State_____

Zip code: _____Home phone (_____)_____birthday_____/___/_____

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Employer: _____Occupation:_____

Work address:_____ City:_____State_____

cell/pager# (_____)_____

Zip code:_____Work phone#(_____)_____

Email address:_____

Social Security # :_____ Driver License_____

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Spouse's name: _____Birthday: _____/_____/_____

Employer: _____Occupation:_____

Work address:_____City:_____State:_____

Zip code:_____Workphone#(_____)_____

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Primary insurance: _____Group #: _____

Insured's name: _____Birthday: _____/_____/____

Social Security #:_____Relation to patient_____eff.date:_____

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Referred by: _____

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Patients with dental insurance should remember that professional services are rendered and charged to the patient. Any benefits that you may receive from your insurance company are a matter of settlement between you and your insurance carrier.

I understand the above paragraph and acknowledge full responsibility for the payment of services and agree to pay them in full, at the time of services, unless other arrangements are made with the office.

Signature_____Date_____