HEALTH HISTORY

Hughes Dental Group
Personalized & Comfortable

Patient Name _____ Birth Date _____

Medical Doctor _____ M.D. Phone No. _____
Is your general health good? _____
Do you have an existing illness? _____
Has there been a change in your health in the last year? _____
Have you been hospitalized in the last year? _____ If yes, why? _____

Have you taken Fen Phen? _____
Do you take or have you had Bisphosphonate therapy? *(i.e. Boniva, Fosomax, Skeli, Actonal)* _____
What medications are you taking at this time? _____
_____

Have you had joint replacement? _____
Do you have an artificial heart valve? _____
Do you have a history of infective endocarditis? _____
Have you had a cardiac transplant that developed cardiac valvulopathy? _____
Do you have congenital heart defects, repaired or unrepaired? If so explain. _____
Are you allergic to latex? _____
Are you allergic to any medications? _____ Which drugs or medications? _____
Are you allergic to metals or jewelry? _____

WOMEN ONLY: Are you pregnant or nursing? _____ Do you take birth control pills? _____

Please circle if you have had or have at the present time any of the following:

Chest Pain	**Swollen Ankles**	**Shortness of Breath**	**Stroke**
Recent Weight Loss	**Persistent Cough**	**Bleeding Problems**	**Herpes**
Sinus Problems	**Difficulty Swallowing**	**Nausea**	**Thyroid Disease**
Difficulty Urinating	**Blood In Urine**	**Dizziness**	**High Blood Pressure**
Ringing In The Ears	**Headaches**	**Seizures**	**Stomach Problems/Ulcer**
Blurred Vision	**Fainting Spells**	**Excessive Thirst**	**Diabetes**
Frequent Urination	**Dry Mouth**	**Jaundice**	**Hepatitis/Liver Disease**
Joint Pain	**Asthma, Tb, Emphysema**	**Heart Disease**	**Kidney Disease**
Aids/HIV Positive	**Heart Attack/Heart Defects**	**Tumors/Cancer**	**Radiation Treatment**
Heart Murmur	**Arthritis/Rheumatism**	**Rheumatic Fever**	
Eye Disease	**Skin Disease**	**Anemia**	

Do you have or have you had any other disease or medical problem not listed on this form?

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

RECALL REVIEW

1. Patient's Signature _____ Date _____
2. Patient's Signature _____ Date _____
3. Patient's Signature _____ Date _____

DENTAL HISTORY

Hughes Dental Group
Personalized & Comfortable

Date _____

Are you in pain today? _____
Do you have any present dental complaints? _____ Explain _____
Name of previous dentist? _____ Phone number or city _____

Are you happy with your smile? _____

When was your last full mouth set of x-rays taken? _____
When was your last cleaning? _____

Do you need to take Pre-Med? _____
Have you had any serious trouble with previous dental treatment? _____ Explain _____
Have you had any problems with local dental anesthesia? _____

Please circle if you have had or have at the present time any of the following:

Abcess In Mouth	**Any Food Traps**	**Bad Breath**
Bad Tastes In Mouth	**Bite Nails**	**Bleeding Gums**
Blisters On Lips Or In Mouth	**Chew On One Side Only**	**Chew Tobacco**
Clenching/Grinding Teeth	**Cold Sores**	**Difficulty Chewing**
Dry Mouth	**Gag Easily**	**Infection Of The Gums**
Loose Teeth	**Missing Teeth**	**Pain Around Ears**
Pain In Jaw Joint	**Sensitive Teeth**	**Sensitive Gums**
Stained Teeth	**Swelling**	**Unusual Noises When You Eat**

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. If there are any changes in my health I will inform the doctor.

I authorize the doctor to take radiographs, study models, photographs or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs.

I give my consent to use local anesthetic.
I give my consent for the use of nitrous oxide gas if I have requested its use.
I authorize Hughes Dental Group to bill and receive payments from my insurance company.
I authorize Hughes Dental Group the use of this signature on all insurance submissions.
I authorize Hughes Dental Group to release all information necessary to secure the payment of benefits.

I UNDERSTAND THAT I AM FULLY FINANCIALLY REPONSIBLE FOR ALL CHARGES COVERED OR NOT COVERED BY MY INSURANCE COMPANY.

Patient's Signature _____ Date _____