sarah winter
DENTAL

PATIENT HEALTH HISTORY

TODAY'S DATE (mm/dd/yyyy): _____

PERSONAL INFORMATION

NAME (Last, First Middle): _____

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH (mm/dd/yyyy): _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PREFERRED PHONE: _____ ALTERNATE PHONE: _____

EMAIL: _____

NAME OF SPOUSE (Last, First Middle): _____

ACCOUNT INFORMATION

PERSON RESPONSIBLE FOR THIS ACCOUNT: _____

EMPLOYER: _____ SOCIAL SECURITY NUMBER: _____

EMERGENCY CONTACT

NAME (Last, First Middle): _____

RELATIONSHIP: _____ PHONE NUMBER: _____

ADDITIONAL INFORMATION

REASON FOR TODAY'S VISIT: _____

_____

HOW DID YOU HEAR ABOUT US: _____

MEDICAL INFORMATION

ARE YOU UNDER THE CARE OF A PHYSICIAN: ☐ YES ☐ NO DATE OF LAST PHYSICAL WELLNESS VISIT (mm/dd/yyyy): _____

NAME OF PHYSICIAN: _____ PHONE NUMBER: _____

CURRENT MEDICATIONS INCLUDING HOMEOPATHIC REMEDIES: _____

_____

_____

MEDICAL INFORMATION (CONTINUED)

PLEASE MARK THE CORRECT BOX TO INDICATE IF YOU HAVE, HAVE NOT, OR DON'T KNOW IF YOU'VE HAD ANY OF THE FOLLOWING:

	YES	NO	DK
ALLERGIES	☐	☐	☐
ARTIFICIAL HEART VALVE	☐	☐	☐
ARTIFICIAL JOINTS	☐	☐	☐
ASTHMA	☐	☐	☐
BLOOD DISEASE	☐	☐	☐
BRUISE EASILY	☐	☐	☐
CANCER	☐	☐	☐
CHEMOTHERAPY	☐	☐	☐
DIABETES	☐	☐	☐
DIZZINESS/FAINTING	☐	☐	☐
DRUG ADDICTION	☐	☐	☐
EMPHYSEMA	☐	☐	☐
EXCESSIVE BLEEDING	☐	☐	☐
GLAUCOMA	☐	☐	☐
HEART CONDITIONS	☐	☐	☐
HEART MURMUR	☐	☐	☐
HEPATITIS A/B/C	☐	☐	☐
HIGH BLOOD PRESSURE	☐	☐	☐
HIV/AIDS	☐	☐	☐
JAUNDICE	☐	☐	☐
KIDNEY DISEASE	☐	☐	☐
LIVER DISEASE	☐	☐	☐
MITRAL VALVE PROLAPSE	☐	☐	☐
NERVOUSNESS/DEPRESSION	☐	☐	☐
PACEMAKER	☐	☐	☐
RADIATION (HEAD/NECK)	☐	☐	☐
RESPIRATORY PROBLEMS	☐	☐	☐
RHEUMATIC FEVER	☐	☐	☐
RHEUMATISM	☐	☐	☐
SCARLET FEVER	☐	☐	☐
SEIZURES	☐	☐	☐
STOMACH PROBLEMS	☐	☐	☐
STROKE	☐	☐	☐
HISTORY OF SMOKING OR CHEWING TOBACCO	☐	☐	☐
THYROID DISEASE	☐	☐	☐
TUBERCULOSIS	☐	☐	☐
ULCERS	☐	☐	☐

FOR WOMEN ONLY:

	YES	NO	DK
BIRTH CONTROL PILLS	☐	☐	☐
BREAST-FEEDING	☐	☐	☐
PREGNANT	☐	☐	☐

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING:

	YES	NO	DK
ASPIRIN	☐	☐	☐
ERYTHROMYCIN	☐	☐	☐
LATEX	☐	☐	☐
LOCAL ANESTHETIC	☐	☐	☐
PENICILLIN	☐	☐	☐
CODEINE	☐	☐	☐
OTHER _____			

DENTAL INFORMATION

CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU:

SENSITIVITY (HOT, COLD, SWEET) ☐	JAW JOINT PAIN ☐	BLEEDING GUMS ☐
HEADACHES, EAR ACHES, NECK PAIN ☐	BROKEN TEETH OR FILLINGS ☐	LOOSE, SHIFTING, TIPPING TEETH ☐
COLD SORES OR MOUTH ULCERS ☐	GRINDING OR CLENCHING ☐	BAD BREATH / BAD TASTE IN YOUR MOUTH ☐

HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING:

DENTURES OR PARTIAL DENTURES ☐	BRACES ☐	GUM TREATMENTS ☐

DATE OF LAST DENTAL EXAM: _____ DATE OF LAST DENTAL HYGIENE VISIT: _____

DATE OF LAST ORAL CANCER SCREENING: _____ DATE OF LAST COMPLETE X-RAYS: _____

NAME OF PREVIOUS DENTIST: _____ PHONE NUMBER: _____

WHAT IS THE MOST IMPORTANT THING TO YOU ABOUT YOUR FUTURE SMILE AND DENTAL HEALTH? _____

_____

IF YOU COULD CHANGE YOUR SMILE, YOU WOULD:

MAKE MY TEETH WHITER ☐	REPAIR CHIPPED TEETH ☐	REPLACE OLD CROWNS THAT DONT MATCH ☐
MAKE MY TEETH STRAIGHTER ☐	REPLACE MISSING TEETH ☐	REPLACE METALS FILLINGS WITH TOOTH ☐
CLOSE SPACES ☐	HAVE A SMILE MAKEOVER ☐	COLORED FILLINGS ☐

ON A SCALE OF 1 (NOT GOOD) - 10 (AMAZING!), HOW IMPORTANT IS YOUR DENTAL HEALTH TO YOU? _____

ON A SCALE OF 1-10, WHERE WOULD YOU RATE YOUR CURRENT DENTAL HEALTH? _____

WHAT IS THE MOST IMPORTANT THING TO YOU ABOUT YOUR DENTAL VISIT TODAY? _____

HAVE YOU HAD ANY BAD DENTAL EXPERIENCES? IF YES, PLEASE TELL US A LITTLE ABOUT IT: _____

_____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and their staff will rely on this information for treating me. 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 member of their staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

SIGNATURE OF PATIENT/LEGAL GUARDIAN: _____ DATE: _____