



Adult Dental-Health History Form

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you.

Name: _____ Date: _____
 Cell Phone: (____) _____ Home Phone: (____) _____ SS# _____
 Address: _____ City: _____ State: _____ Zip: _____
 Email: _____ Date of Birth: ____/____/____ Sex: Male / Female
 Spouse or Parent/Guardian's Name: _____ Phone: (____) _____
 Relationship: _____ Employer: _____ Phone: (____) _____
 Emergency Contact: _____ Relationship: _____ Phone: (____) _____
 Who can we thank for referring you to our office? _____

Do you have Dental Insurance: Yes / No
 Name of Insured: _____ Relationship to Patient: _____
 Date of Birth: _____ SSN: _____ Date Employed: _____ Name
 of Employer: _____ Work Phone: (____) _____ Employer
 Address: _____ City: _____ State: _____ Zip: _____ Insurance
 Company: _____ Group #: _____ Policy/ID#: _____

Do you have secondary Dental Insurance? Yes / No
 Name of Insured: _____ Relationship to Patient: _____
 Date of Birth: _____ SSN: _____ Date Employed: _____
 Name of Employer: _____ Work Phone: (____) _____
 Employer Address: _____ City: _____ State: _____ Zip: _____
 Insurance Company: _____ Group #: _____ Policy/ID#: _____

Previous Dentist: _____ Location: _____ Phone: (____) _____
 Date of last dental exam: _____ Date of last dental x-rays: _____
 What dental values are most important to you? Comfort _____ Cosmetic _____ Longevity _____
 Please explain: _____
 What made you want to switch Dentists? _____

Please answer questions below

- | | Yes | No | | Yes | No |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Do your gums bleed while brushing or flossing? | <input type="checkbox"/> | <input type="checkbox"/> | 8. Do you have frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are your teeth sensitive to hot or cold liquids/foods? | <input type="checkbox"/> | <input type="checkbox"/> | 9. Do you clench or grind your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are your teeth sensitive to sweet or sour liquids/foods? | <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you bite your lips or cheeks frequently? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are your teeth painful? | <input type="checkbox"/> | <input type="checkbox"/> | 11. Have you ever had any difficult extractions in the past? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any sores or lumps in or near your mouth? | <input type="checkbox"/> | <input type="checkbox"/> | 12. Have you ever had any prolonged bleeding following extractions? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any head, neck or jaw injuries? | <input type="checkbox"/> | <input type="checkbox"/> | 13. Have you had any orthodontic treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever experienced any of the following problems in your jaw? | <input type="checkbox"/> | <input type="checkbox"/> | 14. Do you wear dentures or partials? | <input type="checkbox"/> | <input type="checkbox"/> |
| Clicking | <input type="checkbox"/> | <input type="checkbox"/> | If yes, date of placement? _____ | | |
| Pain (joint, ear, side of face) | <input type="checkbox"/> | <input type="checkbox"/> | 15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty in opening or closing | <input type="checkbox"/> | <input type="checkbox"/> | 16. Do you like your smile? | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty in chewing | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Patient Medical History

1. Are you under medical treatment now? Yes No
 If yes, please explain: _____

2. Physician's Name: _____ Yes No
 Phone No: (____) _____
3. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? Yes No
 If yes, please explain _____
4. Are you taking any medication(s) including non-prescription medicine? Yes No
 If yes, what medication(s) are you taking? _____

5. Have you ever taken Phen-Fen/Redux, Fosomax, Boniva, Actonel or any other medications containing Bisphosphonate? Yes No
6. Do you use tobacco? How Long? _____ Yes No
 Cigarettes _____
 Chewing Tobacco _____
7. Do you use controlled substances? Yes No
 If so, what? _____

8. Are you on a special diet? Yes No
9. Are you allergic to or have you had any reactions to the following: Yes No
- Local Anesthetics (e.g. Novocain) Penicillin or any other Antibiotics (Sulfa, etc) Yes No
- Drugs Yes No
- Barbiturates Yes No
- Sedatives Yes No
- Iodine Yes No
- Aspirin Yes No
- Any Metals (e.g. nickel, mercury, etc.) Latex Yes No
- Rubber Yes No
- Other _____ Yes No
10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? Yes No
11. Do you have problems swallowing? Yes No
- Women Only:**
12. Are you pregnant, trying or think you may be pregnant? Yes No
13. Are you nursing? Yes No
14. Are you taking oral contraceptives? Yes No
15. Are you on hormone replacement therapy? Yes No
16. Are you on calcium replacement medications? Yes No

Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
AIDS/HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Anaphylaxis	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells/Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Cough	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Jaw Joints	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Parathyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis/Gout	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Genital Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatments	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joint	<input type="checkbox"/>	<input type="checkbox"/>	GERD or Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Renal Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack/Failure Heart	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
Breathing Problem	<input type="checkbox"/>	<input type="checkbox"/>	Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble/Disease	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia/Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A, B or C	<input type="checkbox"/>	<input type="checkbox"/>	Snoring/Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
Cold Sores/Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Spina Bifida	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Disorder	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Intestinal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone Medicine	<input type="checkbox"/>	<input type="checkbox"/>	Hives or Rash	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of Limbs	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes I or II	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Tumors/Growths/Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice	<input type="checkbox"/>	<input type="checkbox"/>

Any additional information you think we should know: _____

X _____ Date: _____ Date: _____

Signature of patient (or parent/guardian if minor)