New Patient Information & 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. This office does not use this information to discriminate.

Name:_____ DOB: _____
LAST FIRST MIDDLE INITIAL

Address:_____
MAILING ADDRESS CITY STATE ZIP

Home Phone: (_____)_____ Cell Phone: (_____)_____
INCLUDE AREA CODE INCLUDE AREA CODE

What is your preferred contact method? ☐ Home ☐ Cell
Text OK? ☐ Yes ☐ No

SSN: _____ Email Address: _____

Employer/Occupation: _____ Work Phone: (_____)_____
INCLUDE AREA CODE

Emergency Contact: _____ Relationship: _____ Phone: (_____)_____
INCLUDE AREA CODE

Who may we thank for referring you? _____

INSURANCE INFORMATION

Insurance Carrier: _____ Subscriber: _____

ID Number: _____ Sub DOB: _____ Sub SSN: _____

Group Number: _____ Relationship to Patient: _____

Employer: _____

If you have additional insurance, please provide this information to our office staff.

DENTAL INFORMATION

What was the date of your last dental exam: _____ Date of last dental x-rays: _____

What was done at that time? _____

Have you ever had a deep cleaning? Yes ☐ No ☐ Have you ever had any unfavorable dental experiences? Yes ☐ No ☐

Why did you leave your previous dentist? _____

MEDICAL INFORMATION

Are you currently under the care of a physician?.....Yes ☐ No ☐

Physician/Facility: _____

Phone Number: (_____)_____

Address/City/State: _____

_____

Has there been any change in your general health within the past year?.....Yes ☐ No ☐

If yes, what condition is being treated?_____

_____

Date of last physical exam:_____

Have you had a serious illness, operation or been hospitalized in the past 5 years?..... Yes ☐ No ☐

If yes, what was the illness or problem? _____

_____

Are you taking or have you recently taken any prescription or OTC medications?..... Yes ☐ No ☐

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements: _____

_____

_____

MEDICAL INFORMATION (continued..)

Joint Replacement: Have you ever had an orthopedic total joint (hip, knee, elbow, finger) replacement..... Yes ☐ No ☐
Date: _____ If yes, any complications?_____

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax) or risedronate (Actonel) for osteoporois or Paget's disease?..... Yes ☐ No ☐

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?.....Yes ☐ No ☐

Allergies: Are you allergic to or have you had a reaction to:

Local anesthetics.....Yes ☐No ☐
Hay fever/seasonal..... Yes ☐No ☐
Penicillin or other antibiotics..... Yes ☐No ☐
Barbiturates, sedatives, or sleeping pills..... Yes ☐No ☐
Sulfa drugs..... Yes ☐No ☐
Codeine or other narcotics..... Yes ☐No ☐
Latex (rubber)..... Yes ☐No ☐
Iodine..... Yes ☐No ☐
Other? _____

WOMEN ONLY: Are you pregnant?..... Yes ☐No ☐
If yes, number of weeks: _____
Nursing?..... Yes ☐No ☐
Are you currently taking birth control pills or hormone replacement?..... Yes ☐No ☐

Do you use tobacco? (smoking, snuff, chew)..... Yes ☐No ☐
Do you drink alcoholic beverages?..... Yes ☐No ☐
Do you use controlled substances (drugs)?..... Yes ☐No ☐

Please make additional notes or remarks where needed

Artificial (prosthetic) Heart Valve..... Yes ☐No ☐
Congenital Heart Disease..... Yes ☐No ☐
Cardiovascular Disease..... Yes ☐No ☐
Angina..... Yes ☐No ☐
Congestive Heart Failure..... Yes ☐No ☐
Heart Attack..... Yes ☐No ☐
Heart Murmur..... Yes ☐No ☐
Low blood pressure..... Yes ☐No ☐
High blood pressure..... Yes ☐No ☐
Mitral Valve Prolapse..... Yes ☐No ☐
Pacemaker..... Yes ☐No ☐
Rheumatic Fever..... Yes ☐No ☐
Abnormal Bleeding..... Yes ☐No ☐
Anemia..... Yes ☐No ☐
Hemophilia..... Yes ☐No ☐
AIDS or HIV infection..... Yes ☐No ☐
Arthritis..... Yes ☐No ☐
Autoimmune Disease..... Yes ☐No ☐
Liver disease/Hepatitis A, B or C..... Yes ☐No ☐
Night sweats..... Yes ☐No ☐

Asthma..... Yes ☐No ☐
Bronchitis..... Yes ☐No ☐
Emphysema..... Yes ☐No ☐
Sinus Trouble..... Yes ☐No ☐
Frequent Headaches..... Yes ☐No ☐
Cancer/Chemo/Radiation Treatment..... Yes ☐No ☐
Chronic Pain..... Yes ☐No ☐
Diabetes (type I or II)..... Yes ☐No ☐
Eating Disorder..... Yes ☐No ☐
G.E. Reflux/Heartburn..... Yes ☐No ☐
Thyroid Problems..... Yes ☐No ☐
Stroke..... Yes ☐No ☐
Glaucoma..... Yes ☐No ☐
Epilepsy..... Yes ☐No ☐
Fainting Spells/Seizures..... Yes ☐No ☐
Neurological Disorder.....Yes ☐No ☐
Sleep Disorder..... Yes ☐No ☐
Mental Health Disorder..... Yes ☐No ☐
Kidney Problems..... Yes ☐No ☐
Osteoporosis.....Yes ☐No ☐

Has your physician recommended you take a premedication before dental treatment?.....Yes ☐No ☐
Name of physician making recommendation: _____ Phone:_____
Do you have a disease, condition or problem not listed above that we should know about?.....Yes ☐No ☐
If yes, please explain:_____

I understand that the information that I have provided is correct to the best of my knowledge. I will not hold my dentist, or any other member of his 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. I understand that this form will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

_____ _____
PATIENT/GUARDIAN SIGNATURE DATE