IMPLANT & GENERAL DENTISTRY

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.

First Name: **Middle Initial:** **Last Name:** Prefer to be called:

Address: City: State: Zip:

SS# **DL# :** Height: Weight: DOB: Sex: M F

Email: Home Phone: include Area Code ( ) Cell Phone: include Area Code ( )

Emergency Contact: Home Phone: include Area Code ( ) Cell Phone: include Area Code ( )

Employer: Work Phone: include Area Code ( ) **How did you hear about us?**

Marital Status: Spouse: Spouse DOB: Cell Phone: include Area Code ( )

☐ **Check if completing for someone else** Name: Phone: ( )

Dental Insurance

Primary Dental Insurance

Policy Holder Name: **DOB:** **Policy Holder SS#:**

Policy Holder Employer: **Relation to Policy Holder:**

Insurance Company Name: **Insurance Company Phone:** ( )

Insurance Company Address:

Identification #: **Group #(Plan, Local, or Policy #):**

Secondary Dental Insurance

Policy Holder Name: **DOB:** **Policy Holder SS#:**

Policy Holder Employer : **Relation to Policy Holder:**

Insurance Company Name: **Insurance Company Phone:** ( )

Insurance Company Address:

Identification #: **Group #(Plan, Local, or Policy #):**

Dental Information

Please mark (X) your response to the following questions.

	Y	N		Y	N
Do you like your smile?	☐	☐	Have you had a serious injury to your head or mouth?	☐	☐
Have you ever had braces?	☐	☐	Do you wear partials or dentures?	☐	☐
Have you ever had peridontal treatment?	☐	☐	Have you experienced problems with previous dental treatment?	☐	☐

Date of last dental exam: Date of last dental x-rays:

Reason for today's visit?

Do you experience?

	Y	N		Y	N		Y	N
Bleeding Gums	☐	☐	Grinding/Clenching	☐	☐	Sores/Ulcers	☐	☐
Sensitivity	☐	☐	Jaw Clicking/Popping	☐	☐	Earaches	☐	☐
			Dry Mouth	☐	☐	Neck pain	☐	☐

Allergies

Please indicate if you are allergic to any of the following:

	Y	N	DK		Y	N	DK		Y	N	DK
Dental Anesthetics	☐	☐	☐	Sedatives or sleeping pills	☐	☐	☐	Latex	☐	☐	☐
Aspirin	☐	☐	☐	Codeine	☐	☐	☐	Iodine	☐	☐	☐
Penicillin or other antibiotic	☐	☐	☐	Metals	☐	☐	☐	Sulfa drugs	☐	☐	☐
Other (please list)	☐	☐	☐								

Medical Information

Physician Name: Date of Last Exam: Phone Number: include area code

	Y	N
Are you under the care of a physician?	☐	☐
Are you in good health?	☐	☐
Have you had any changes in your general health?	☐	☐
Have you had surgery or been hospitalized within the past five years?	☐	☐

Antiresorptive agents may cause complications post dental procedures. Please indicate if you have taken, are taking, or are scheduled to take any of the following antiresorptive agents for any condition (e.g., osteoporosis, Paget's disease, bone pain, hyercalcemia, or skeletal complications related to multiple myeloma or metastatic cancer).

Fosamax	☐	Actonel	☐	Atelvia	☐	Other	☐
Boniva	☐	Reclast	☐	Prolia	☐		
Aredia	☐	Zometa	☐	XGEVA	☐		

Have you had an orthopedic total joint replacement? ☐hip ☐knee ☐elbow ☐finger ☐none
Have you had a heart valve replacement or heart transplant? ☐valve ☐heart ☐none
Surgeon Name: Phone Number:
Date: Were there any complications? ☐ Yes ☐ No
Have you had previous infective endocarditis? ☐ Yes ☐ No
If transplant, are there damaged valves in transplanted heart? ☐ Yes ☐ No
Do you have congenital heart disease? ☐ Yes ☐ No If so, explain _____

Medical Information Please indicate if you have or have not had any of the following conditions.

	Y	N	DK
cardiovascular disease	☐	☐	☐
angina	☐	☐	☐
arteriosclerosis	☐	☐	☐
congestive heart failure	☐	☐	☐
damaged heart valves	☐	☐	☐
heart attack	☐	☐	☐
heart murmur	☐	☐	☐
low blood pressure	☐	☐	☐
high blood pressure	☐	☐	☐
mitral valve prolapse	☐	☐	☐
other congenital heart defects	☐	☐	☐
pacemaker	☐	☐	☐
rheumatic fever	☐	☐	☐
rheumatic heart disease	☐	☐	☐
abnormal bleeding	☐	☐	☐
anemia	☐	☐	☐
blood transfusion	☐	☐	☐
if yes, date: _____			
hemophilia	☐	☐	☐
AIDS/HIV infection	☐	☐	☐
arthritis	☐	☐	☐

	Y	N	DK
autoimmune disease	☐	☐	☐
rheumatoid arthritis	☐	☐	☐
asthma	☐	☐	☐
bronchitis	☐	☐	☐
emphysema	☐	☐	☐
sinus trouble	☐	☐	☐
tuberculosis	☐	☐	☐
cancer/chemotherapy/ radiation treatment	☐	☐	☐
chest pain upon exertion	☐	☐	☐
chronic pain	☐	☐	☐
diabetes type I or II	☐	☐	☐
eating disorder	☐	☐	☐
malnutrition	☐	☐	☐
gastrointestinal disease	☐	☐	☐
GE Reflux/persistent	☐	☐	☐
heartburn	☐	☐	☐
ulcers	☐	☐	☐
thyroid problems	☐	☐	☐
stroke	☐	☐	☐
glaucoma	☐	☐	☐
hepatitis, jaundice, or liver disease	☐	☐	☐

	Y	N	DK
epilepsy	☐	☐	☐
fainting spells or seizures	☐	☐	☐
neurological disorders	☐	☐	☐
if yes, specify: _____			
sleep disorder	☐	☐	☐
snoring	☐	☐	☐
mental health disorder	☐	☐	☐
if yes, specify: _____			
recurrent infections	☐	☐	☐
type of infection:	☐	☐	☐
kidney problems	☐	☐	☐
night sweats	☐	☐	☐
osteoporosis	☐	☐	☐
persistent swollen neck glands	☐	☐	☐
severe headaches/migraines	☐	☐	☐
severe or rapid weight loss	☐	☐	☐
sexually transmitted disease	☐	☐	☐
excessive urniation	☐	☐	☐
pregnant	☐	☐	☐
nursing	☐	☐	☐
hormone replacement therapy/birth control pills	☐	☐	☐

Has a physician or dentist recommended that you take antibiotics prior to your dental treatment? Y ☐ N ☐ DK ☐

Name of recommending physician or dentist: Phone Number: Include Area Code ( )

Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ Y ☐ N If yes, please explain.

Do you use controlled substances (drugs)? Y ☐ N ☐

Do you use tobacco (smoking, snuff, chew, bidis)? Y ☐ N ☐

If so, how interested are you in stopping?
☐ Very ☐ Somewhat ☐ Not interested

Do you drink alcoholic beverages? Y ☐ N ☐

If yes, how much alcohol did you drink in the last 24 hours?

If yes, how much do you typically drink in a week?

Note: 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 give on this form is accurate. I understand the importance of a factual health history and that my dentist and staff will rely on this information while 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 staff responsible for any action they take or do not take because of errors or omissions I may have made in the completion of this form.

Patient/Legal Guardian Signature_____ Date: _____

Dentist/Dental Staff Signature_____ Date: _____

Medical History Update

Date:	Comment:	Signature
Date:	Comment:	Signature:
Date:	Comment:	Signature:

Appointments: Our goal is to provide quality dental care in timely manner. For this reason, we have implemented an appointment cancellation policy to enable us to better utilize available appointments for our patients in need of dental care. Appointments are in high demand; therefore, if you must cancel your appointment, we require 24 hours notice. Your early cancellation allows us to rebook the appointment to allow another patient to access dental care. Appointments that are missed or cancelled without 24 hours notice will result in a $30 cancellation fee charged to the patient's account.

Financial Policies: Dental services are to be paid for on the day service is rendered. If a service requires more than one visit (e.g., a crown), you may pay 1/2 of the fee at the start of the treatment and the remainder of the balance to be paid in full upon completion of treatment. We accept Visa, Mastercard, American Express, & Discover. *ALL OVERDUE ACCOUNTS WILL RECEIVE A $15.00 MONTHLY LATE FEE THAT BECOMES THE RESPONSIBILITY OF THE ACCOUNT HOLDER TO PAY.* If your account is placed for collections, the undersigned agrees to pay all attorney & collection fees.

Insurance: We will bill your dental insurance carrier as a courtesy to you. You are responsible for payment of your estimated portion on the day of service. Once your carrier is billed, payment must be made in full within 60 days. You are responsible for payment of the full balance if your insurance carrier does not remit payment within 60 days.

*Please be advised that we do not file medical claims. We do not have access to medical diagnosis or treatment codes. If you have treatment rendered that you would like to file with your medical insurance carrier, it is your responsibility to do so.

Philosophy: Our goal is to provide the best dental care possible. Proper dental care enhances your well being. We want you to feel good about yourself and your oral health. Please feel free to ask us any questions. We are honored to serve you, your family, and your friends.

I have read and agree to the above policy.

Patient/Legal Guardian Signature_____ Date: _____

Medication & Supplement Record Include ALL presecription drugs, OTC medications, vitamins, & supplements.

Medication or Supplement	Purpose or condition:	Dosage	Frequency	Time(s) of Day Taken	Form of administration	Date began:	Date ended:	Have you taken this medication today?
				☐AM ☐PM	☐ Oral ☐Injection ☐IV ☐ Inhaler☐ Transdermal			☐ Y ☐ N
				☐AM ☐PM	☐ Oral ☐Injection ☐IV ☐ Inhaler☐ Transdermal			☐ Y ☐ N
				☐AM ☐PM	☐ Oral ☐Injection ☐IV ☐ Inhaler☐ Transdermal			☐ Y ☐ N
				☐AM ☐PM	☐ Oral ☐Injection ☐IV ☐ Inhaler☐ Transdermal			☐ Y ☐ N
				☐AM ☐PM	☐ Oral ☐Injection ☐IV ☐ Inhaler☐ Transdermal			☐ Y ☐ N
				☐AM ☐PM	☐ Oral ☐Injection ☐IV ☐ Inhaler☐ Transdermal			☐ Y ☐ N
				☐AM ☐PM	☐ Oral ☐Injection ☐IV ☐ Inhaler☐ Transdermal			☐ Y ☐ N
				☐AM ☐PM	☐ Oral ☐Injection ☐IV ☐ Inhaler☐ Transdermal			☐ Y ☐ N
				☐AM ☐PM	☐ Oral ☐Injection ☐IV ☐ Inhaler☐ Transdermal			☐ Y ☐ N
				☐AM ☐PM	☐ Oral ☐Injection ☐IV ☐ Inhaler☐ Transdermal			☐ Y ☐ N
				☐AM ☐PM	☐ Oral ☐Injection ☐IV ☐ Inhaler☐ Transdermal			☐ Y ☐ N
				☐AM ☐PM	☐ Oral ☐Injection ☐IV ☐ Inhaler☐ Transdermal			☐ Y ☐ N
				☐AM ☐PM	☐ Oral ☐Injection ☐IV ☐ Inhaler☐ Transdermal			☐ Y ☐ N
				☐AM ☐PM	☐ Oral ☐Injection ☐IV ☐ Inhaler☐ Transdermal			☐ Y ☐ N
				☐AM ☐PM	☐ Oral ☐Injection ☐IV ☐ Inhaler☐ Transdermal			☐ Y ☐ N